Resident Physician

MAY 196

Vol. 7 . No.

TABLE FOR THE HOSPITAL STAFF OFFICER

5. 26.17

EQUIPPING

THE

hese

(C), (C),

ME

sician

URGEON'S

OFFICE

Mediquiz Contest Answers &

References

CAMP

Not so Gentle



D. 44

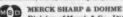
MD's Wanted Now!



In a series of 24 handicapped arthritics treated with dexamethasone for 8 to 16 months, ring size decreased consistently—objective evidence of antirheumatic effects which were maintained throughout the entire period of observation. Improvement was also noted in other antirheumatic indices, i. e., pain on motion, tenderness, swelling and morning stiffness.¹

Supplied: as 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate and new Elixir DECADRON. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

Reference: 1. Bunim, J. J., in Hollander, J. L.: Arthritis and Allied Conditions, ed. 6, Philadelphia, Lea & Febiger, 1960, p. 364.



Division of Merck & Co., INC., West Point, Pa.

Decadron Treats More PATIENTS MORE EFFECTIVELY

May 1

May 1961, Vol. 7, No.

The Resid

n the fift

y The Re

ith publ

Resident Physician

Articles

- 57 Problem of Foreign Medical Graduates— Let's Do Something About It!
- 64 CPC-manship: The Not-So-Gentle Art of Case Presentation
- 70 Equipping the Surgeon's Office
- 77 Clinical Pathological Conference
- 92 Washington Hospital Center
- 114 Guest Editorial: Teaching Hospitals and the 'Doctor Shortage'
- 122 Camp MDs Wanted Now!
- 130 Tips on Handling Your Checking Account
- 136 Military Service with a Smile
- 142 Hospital Administration and Medical Education
- 148 Key Words for the Clinic— The Doctor Speaks Yiddish
- 156 Mediquiz Contest Answers & References

The Resident Physician is published monthly n the fifteenth y The Resident, Inc., with publication offices at 34 North Crystal Street, East Stroudsburg. Pennsylvania. Executive, advertising ad editorial offices at 147 Northern Boulevard, Manhasset, New York. If undelivered, please send em 3547 to Resident Physician, 1447 Northern Soulevard, Manhasset, lew York.

May 1961, Vol. 7, No.

in G.I., G.U. and Biliary SPASM

"Murel"s.a.

Sustained Action Tablets

prompt, continuous and prolonged antispasmodic action for 6 to 9 hours with a single tablet

"MUREL" Advantages1-4

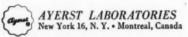
- Exceptionally effective clinically because three-way mechanism of action in one molecule (anticholinergic, musculotropic, ganglionblocking) exerts synergistic spasmolytic effect
- Complementary action permits significantly low dosage and reduces reaction potential of any one mechanism
- Remarkably free from drug-induced complications such as mouth dryness, visual disturbances, urinary retention

Suggested Average Dosage: 40 to 80 mg, daily, depending on coning a pass of the genitourinary and biliary tracts. One "Murel"-5.A. Sustained Action Tablet morning and evening, When anxiety and tension are present, "Murel" with Phenobarb-5.A. is suggested. Available as: No. 315—"Murel".5.A. 40 mg. Valethamate bro-mide; and No. 319—"Murel" with Phenobarb-5.A., with ½ gr. phenobarbital, present as the sodium salt. Both in bottles of 100 and 1,000.

Also available: "Murel" Tablets No. 314—10 mg. Valethamate bromide; "Murel" with Phenobarbital Tablets No. 318—10 mg. Valethamate bromide and ½ gr. phenobarbital.

"Murel" Injectable No. 405—10 mg, Valethamate bromide per cc. Precautions: As with other antispasmodic agents, caution should be exercised in patients with prostatic hypertrophy, glaucoma, and is the presence of cardiac arrhythmias.

References available on request.



for acute, severe episodes

"MUREL" Injectable

Female patient, age 55 complaining of nause and epigastric discomfort after meals.

Diagnosis: Hiatus her nia and gastric ulcer.



1 hour after barium alministration: Retention of barium due to spaticity of the gastric outlet, and incomplete visualization of the pilorus, duodenum and duodenal sweep. (Sone barium has entered the small bowel.)

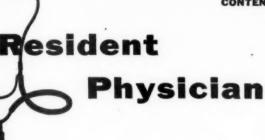


20 minutes after a ministration of "Murd" 2 cc. I.V.: Barium entering duodenum and duodenal sweep as spasticity is relieved.



10 minutes later: Good filling of the gastric outlet as well as of the duodenal sweep.

Medical Records of Ayerst Laboratories 602



Departments

- 15 Therapeutic Reference
- 21 Viewbox Diagnosis

 Compare your findings with those of a top radiologist.
- 27 Resident Relaxer

 Medical crossword puzzle
 for word detectives.
- 31 Letters to the Editor
- 162 Your Wife's Talking
- 166 What's the Doctor's Name?
 Identify this famous physician.
- 168 Mediquiz

 Stay close to your textbooks for this examination.
- 173 Leads and Needs

 Check these practice opportunities and residency openings.
- 186 Advertisers' Index

 Companies whose products and services are advertised in this issue of your journal.

ble 55 use

her

om adention

spasastric mplete

he py-

n and

(Some

ter al-

'Murel"

ium enim and e e p as

lieved.

ter: Goo

gastrid

as of the

af ies 6021

Articles publication

standing t

tributed se

lication,

interest o

value to 1

and intern

lwe copies

should be

May 196



PATIENTS WITH SEVERE URINARY PAIN WANT RELIEF NOW.

Two Pyridium tablets t.i.d. relieve the pain of urinary infection in only 30 minutes. During the first 3 to 4 days of therapy, Pyridium, prescribed along with any antibacterial of your choice, will make your patient comfortable until the antibacterial reduces inflammation and controls the infection.

AVERAGE DOSE: Adults - 2 tablets t.i.d. Children 9 to 12 -1 tablet t.i.d. supplied: 0.1 Gm. tablets, bottles of 50. PRECAUTIONS: Pyridium is contraindicated in patients

with renal insufficiency and/or severe hepatitis. Full dosage information, available on request, should be consulted before initiating therapy.



Resident Physician

Editor-in-Chief Perrin H. Long, M.D., F.R.C.P.

Chairman, Department of Medicine Professor of Medicine, Downstate Medical Center, State University of New York; Visiting Physician Department of Medicine, Kings County Hospital Center, Brooklyn, New York

Managing Editor Robert B. Palmer

Associate Editor John F. Pearson

Resident Staff Director Salvatore R. Cutolo, M.D.

Resident Editor Edward R. Bloomquist, M.D.

Production Katherine C. Weber James F. McCarthy

Art Gill Fox Alex Kotzky

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians and interns. When possible, two copies of the manuscript should be submitted.

Vol.

Chil-

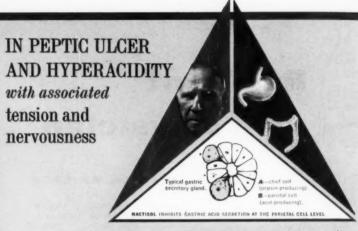
p: 0.1

tients

REP

RESIDENT PHYSICIAN. Contents copyrighted 1961 by The Resident, Inc., Randolph Morando, President; William Leslie, Vice President and Sales Director; Roger Mullaney, Vice President and Sales Manager; Walter J. Biggs, Vice President and Sales, 1447 Northern Boulevard, Manhasset, New York.

Subscription rate \$10 per year. Single copies \$1, Notify publisher promptly of change of address.



NACTISOL

suppresses gastric acid secretion at the parietal cell level decreases gastrointestinal hypermotility relieves nervousness and tension

NACTISOL combines:

NACTON® 4 mg. new inhibitor of gastric acid secretion and hypermotility poldine methylaulistet "...reduces the total output of gastric HCl by about 60%" plus

BUTISOL SODIUM[®] 15 mg. "daytime sedative" with highest therapeutic index² (highly effective, minimal side effects)

Side effects with NACTISOL therapy have been minimal.²⁻⁵

NACTISOL* . . . in scored, yellow tablets

References

Douthwaite, A. H.: The Development of the Treatment of Duodenal Ulcer, Proc. Roy. Soc. Med. 51:1063-1068 (December) 1958.
 Batterman, R. C., Grossman, A. J., Leifer, P., and Mouratoff, G. Li. Clinical Revealuation of Daytime Sedatives, Pougrad. Med. 25:02-599 (October) 1959.
 Steigmann, F.: Clinical Report to McNeil Laboratories.
 Lorber, S. H.: Clinical Report to McNeil Laboratories.

MCNEIL MCNEIL LABORATORIES, INC., Fort Washington, Pa.

*Trademark

tU. S. Patent

Anesth
J. ADRI
ment of
pital of

Max S. partment sity of II

Dermat Marion

MARION fessor as Dermato York Us cal Scho

C. WESL eral Prac versity of

George Practice tal, Balti

Medicine WILLIAM Medicine cal School

CHARLES Professor

Resident Physician

Anesthesiolo

J. ADRIANI, M., Director, Department of Anesthesiology, Charity Hospital of New Orleans.

MAN'S, SADOVE, M.D., Director, Department of Anesthesiology, University of Illinois.

Dermatology

MARION B. SULZBERGER, M.D., Professor and Chairman, Department of Dermatology and Syphilology, New York University Postgraduate Medical School.

General Practice

C. WESLEY EISELE, M.D., Chief, General Practice Residency Program, University of Colorado.

GEORGE ENTWISLE, M.D., General Practice Program, University Hospital, Baltimore.

Medicine

ity

221

ic

cts)

Aed.

F.:

ark tent WILLIAM B. BEAN, M.D., Professor of Medicine, University of Iowa Medical School.

Charles Davidson, M.D., Associate Professor of Medicine, Harvard Medical School.

C. WESLEY EISELE, M.D., Associate Professor of Medicine; Associate Dean in Charge of Post Graduate Medical Education, University of Colorado.

CHARLES L. LEEDHAM, M.D., Director of Education, Cleveland Clinic, Frank E. Bunts Educational Institute.

JOHN C. LEONARD, M.D., Director, House Staff Education, Hartford Hospital.

Obstetrics-Gynecology

ALAN F. GUTTMACHER, M.D., Director, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, New York City.

Ophthalmology

DERRICK T. VAIL, M.D., Chairman, Department of Ophthalmology, Northwestern University Medical School.

Orthopedics

HAROLD A. SOFIELD, M.D., Professor of Orthopedic Surgery, Northwestern University Medical School.

Otolaryngology

DEAN M. LIERLE, M.D., Chief, Department of Otolaryngology and Maxillofacial Surgery, State University of Iowa.

Percodan tablets effectively relieve pain through a range of



intensities commencing with moderate pain and extending



through major traumatic areas into further regions of severe pain







Percodan: Gails of Dhydrohydrauycodoloona axid Hometropina, pius APC) TALLETC

for pain

prompt relief profound relief prolonged relief ACTS FASTER—usually within 5-15 minutes. LASTS LONGER—usually 6 hours or more. MORE THOROUGH RELIEF—permits uninterrupted sleep through the night. RARELY CONSTIPATES —excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit forming. Federal law permits oral prescription.

Each Percodan* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine.

Also available—for greater flexibility in dosage— PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

Endo

LITERATURE AVAILABLE ON REQUEST ENDO LABORATORIES Richmond Hill 18, New York

*U.S. Patent Nos. 2,628,185 and 2,907,788

Patho John I of Path

Lincoln

Pedia

cian-inpital.

Plastic

NEAL Cic, New Surgery Medicin

Psych

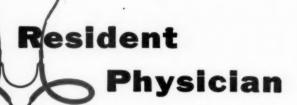
fessor of retary, of Psyc

Public Prevei

Mission York.

Radiol

MAXWE tor of Center.



Pathology

JOHN R. SCHEKEN, M.D., Professor of Pathology, inversity of Nebraska, Lincoln.

Pediatrics

James Marvin Baty, M.D., Physician-in-Chief, Boston Floating Hospital.

Plastic Surgery

NEAL OWENS, M.D., The Owens Clinic, New Orleans; Clinical Professor of Surgery, Tulane University School of Medicine.

Psychiatry

es.

RE

ted

TES

nts.

urs.

oral

ihy-

mg.

mg.

cylic eine.

ge -

oxy-

EST.

07,788

WILLIAM C. MENNINGER, M.D., Professor of Psychiatry and General Secretary, Menninger Foundation School of Psychiatry.

Public Health and Preventive Medicine

HERMAN E. HILLEBOE, M.D., Commissioner of Health, State of New York.

Radiology

MAXWELL H. POPPEL, M.D., Director of Radiology, Bellevue Hospital Center.

Rehabilitation and Physical Medicine

SEDGWICK MEAD, M.D., California Rehabilitation Center, Vallejo.

Resident Staff Director

SALVATORE R. CUTOLO, M.D., Deputy Medical Superintendent, Bellevue Hospital Center.

Surgery

DONALD C. COLLINS, M.D., Assistant Professor of Surgery, College of Medical Evangelists.

EARL J. HALLIGAN, M.D., Director of Surgery, Jersey City Medical Center.

KARL A. MEYER, M.D., Chairman, Department of Surgery, Cook County Hospital.

HOWARD E. SNYDER, M.D., The Snyder Clinic, Winfield, Kansas.

Thoracic Surgery

PAUL C. SAMSON, M.D., Associate Clinical Professor, Stanford University School of Medicine.

Urology

HERBERT B. WRIGHT, M.D., Chief of Urology, Evangelical Deaconess Hospital, Cleveland.

May 1961, Vol. 7, No. 5

in emergencies INJECTION

rocortone PHOSPHATE

in the patient in 30 seconds - in the plasma in 5 minutes

1. No dilution 2. No mixing 3. No waiting . . . in stable solution ready-to-inject with small-bore needle. . Plasma steroid levels are evident within 5 minutes after injection by any route . . . intravenous, intramuscular or subcutaneous.

After intramuscular injection .

higher initial steroid plasma levels than with hydrocortisone hemisuccinate.

After intramuscular or intravenous injection.

more prolonged steroid levels than with hydrocortisone hemisuccinate.

DOSAGE: The usual dose of Injection HYDROCORTONE Phosphate in emergency situations is 100 to 250 mg. depending upon the severity of the condition. For additional information see package circular.

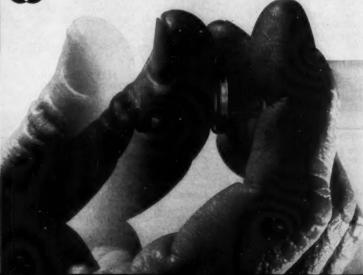
Supplied: In 2-cc. vials, each cc. containing 50 mg. HYDROCORTONE (as hydrocortisone 21-phosphate, disodium salt). Also available—Injection HYDELTRASOL® (prednisolone 21-phosphate) in 2-cc. and 5-cc. vials, each cc. containing 20 mg. of prednisolone 21-phosphate as the disodium salt. Injection DECADRON® Phosphate in 5-cc. vials, each cc. containing 4 mg. dexamethasone 21-phosphate as the disodium salt.

Hydrocortone, Hydeltrasol and Decadron are trademarks of Merck & Co., INC.

Additional information is available to physicians on request.



MERCK SHARP & DOHME, Division of Merck & Co., INC., West Point, Pa.



Allergi Metreto Tedral ! Twiston

Analge Sedativ

Cafergot Dilaudid Percodan Sinutab

Antibio therape Achromy Midicel

Anticoa Coumadi

Antispa Murel-S.

Irthriti Decadror

Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).

Allergic Disorders and Ast	hma
Metreton Tedral SA Twiston	5: 13 4
Analgesics, Narcotics, Sedatives and Anesthetics	
Cafergot	159
Dilaudid	10
Percodan Sinutab Sinutab	133
Antibiotics and Chemo- therapeutic Agents Achromycin IV, IM	34
Anticoagulants	
Coumadin	141
Antispasmodics	
Murel-S.A.	(
Arthritis Disorders and Go	

Cover 2

Cardiovascula	ar	Di	SC	1	d	e	r	S	
Butiserpine Gitaligin									117
Raudixin							10	66,	
Central Nerve		-				_	_		-
Emivan			4	l	tl	11	0	ug	h 45
Contraceptive	es								
Delfen					. ,				169
Koro-Flex									39
Preceptin							ė	*	169
Diabetes									
Orinase			× ×			,		*	54
Diagnostic Ag	gen	ts							
Combistix							(Cov	er 3
Diarrheal Dis	ore	ie	rs						
Furoxone				. 4			*		23
Diuretics									
Diuril		* *						*	135
Dressings									
Scotch Surgical	Ta	pe							105

Decadron

GERIATRIC AGITATION.

Mellaril®

provides highly effective tranquilization, relieves agitation, apprehension, anxiety

and "screens out"
certain side effects
of tranquilizers,
making it
virtually free of:

EXCESSIVE SENATION

ALMOIGE

PAGENESIMA

BUILDING TO SE

PHET DE INSTITUTY

"The value of the phenothlazines as tranquilizers has been established. [However] many distressing side effects have been reported with these drugs. ... Thioridazine [Meliarii] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothlazines."

In Geriatrics "This is the third time the authors have evaluated a tranquilizer in a geriatric group. Our feeling is that Mellaril is superior to the other two, both of which were phenothiazine derivatives."

Mellarii is indicated for varying degrees of agitation, apprehension, and anxiety in both ambulatory and hospitalized patients. Usual starting dose: Non-psychotic patients — 10 or 25 mg, t.i.d. Psychotic patients — 100 mg, t.i.d. Dosage must be individually adjusted until optimal response. Maximum recommended dosage: 800 mg, daily. Supply: Mellarii Tablets, 10 mg, 25 mg, 50 mg, 100 mg. 1. Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959. 2. Judah, L., Murphree, O., and Seager, L.: Am. J. Psychiat. 115:1118, June, 1959.



Equipment and Supplies	Miscellaneous
Amsco Dynapoise32, 33 Daily Log38	Student Anthology 46
Histacount 179 Ultrasonics 3	Plasma Modifiers
Venopak, Secondary 24, 25	Albumisol 127
Feminine Hygiene Tampax	Postoperative and Postpartum Care
Tampax	Urecholine
Foods and Beverages	Oldellome
Sustagen Cover 4	Skin Disorders and Antibacterials
G. U. Preparations and Antiseptics	Achromycin Dermatologic 170 Neo-Polycin Ointment 20
Gantrisin	
Pyridium 8	Steroids and Hormones
Hematinics	Aristocort Opposite page 19; 19 Decadron Phosphate Injection 52
Mol-Iron Chronosules108, 109	Durabolin
Hemorrhoids and Rectal Disorders	Medrol Medules 123 Nilevar 103
Anusol, Anusol-HC 129	
	Tranquilizers
Hemostasis	Compazine, Stelazine,
Premarin Intravenous 4	Thorazine 51 Librium 94, 95 Mellaril 16, 17
Infant Formulas and Milks	Meliani
Baker's Modified Milk 113	Illeer Monogoment
Enfamil	Vicer Management Nactisol
S-M-A	Nactisoi
I.V. Solutions	Varinal Branavations
Levophed	Vaginal Preparations
	Furacin Vaginal Suppositories
Investments and Insurance	Sporostaciii Creaiii
Accident & Hospital Insurance*	Vitamine and Nutrients
Copeland Planned Futures 167	Vitamins and Nutrients
	Stresscaps 155
Laxatives and Anti-	
constipation Preparations	Weight Control
Fleet Enema 121	Adabee 139

May 1961,

and

1. Osteo 2. Inject

Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R., Professor of Radiology, New York University College of Medicine and Director of Radiology, Bellevue Hospital Center



Forty-eight-year-old male with pain in buttocks and both lower extremities, radiating down from the hips.

Which is your diagnosis?

Osteogenic sarcoma

46

127

49

170 20

19 52

14 123

- 3. Soft tissue calcifications
- Injected opaque medication
- 4. Myositis ossificans

(Answer on page 181)



lay 1961, Vol. 7, No. 5

"UPSET STOMACH" ON DIGITALIS 52-year old male had rheumatic heart disease cardiomegaly Grade II, auricular fibrillation, mitral stenosis, mitral insufficiency, and was in class III-C. For 17 months he had been in failure. Three grains of digitalis daily were required for effective maintenance therapy. When the patient began to complain of frequent "upset stomach" he was placed on digitoxin, with an alternating 0.1 and 0.2 daily maintenance dose. Nausea became very severe after two months, and digitoxin was decreased to 0.1 mg. daily. Congestive failung increased and rehospitalization was necessary. Patient was given GITALIGIN, 0.5 mg. q.i.d. for two days, then 1.5 mg. daily for six weeks, followed by 1.0 mg. per day with 1.5 mg. every third day Failure was effectively controlled without toxicity.

"DIGITALIS TOXICITY IS SEEN WITH INCREASING FREQUENCY TODAY..."



for maximal digitalis activity with minimal toxicity

Gitaligin[®]

"...patients who became toxic very readily with other agents could later be satisfactorily digitalized with gitalin (GITALIGIN)."

Wider margin of safety—frequently effective in patients refractory to other digitalis glycosides • broader clinical utility—therapeutic dose only ½ the toxic dose • faster rate of elimination than digitoxin or digitalis leaf.

Supplied: 0.5 mg. scored tablets—bottles of 30 and 100.

1. Dimitroff, S. P. et al.: Ann. Int. Med. 39:1189, 1953. 2. Pastor, B. H.: GP 22:85, 1960.

White

Outsta 4. Pertai Closes 14. Speck IS. Cover Restor 17. Ready as a h On 21. Comp Breath 23. Upon 24. Males Aurich Eterna 29. Sole Small Poem 32. Chines l6th P nickn 35. Petitio 37. Brushe 40. Yes (S 41. Patters Sped 44. Otherv Prohib 47. Large 49. Germa 50. Respire 52. Foot (Whimp 54. Image 56. Path S.R of food 60. Bandas 61. An aci 62. Perforn

63. Sewing invento 64. Nutrim

67. Moham 69. Italian 71. Behold 72. Stop 73. Award 74. Japane

I. Public

2. Finger 3. Greek

4. Sicilian 5. Rouser

Resident Relaxer

(Solution on page 181)

ACROSS

Dise.

las fo ch'

am ilun tw day

991

...

- 1. Outstanding performer 4. Pertaining to apples 9. Closes firmly
- 14. Speck 15. Covered with water 16. Restorative
- 17. Ready to operate, as a hospital
- 21. Compass direction
- 22. Breath (obs.) 23. Upon
- 24. Males 25. Auricles 28. Eternally 29. Sole
- 30. Small medicine bottle
- 31. Poem 32. Chinese weight 34. léth President
- (nickname) Petitioners
- 37. Brushed 40. Yes (Span.)
- 41. Pattern 42. Sped 44. Otherwise
- 45. Prohibition 47. Large artery
- 49. German pronoun
- 50. Respiratory organ 52. Foot (Lat.)
- 53. Whimper 54. Image
- 56. Path Senilis
- 59. Worthless leaving
- of food 40. Bandage
- 61. An acid
- 62. Perform 63. Sewing machine inventor
- 64. Nutriment 67. Mohammedan priests
- 69. Italian city
- 71. Behold 72. Stop

zed with

to other

85, 1960. ew Jersey

3. Award 74. Japanese coin

DOWN

- ster rate es of 30
- I. Public notices
 2. Finger cover
 3. Greek letter
 4. Sicilian bandit society
 5. Rouser of fear

- 20 21 18 23 22 27 28 32 36 42 4 60 62 63 65 66 62 68 69 70

 - 6. Stripling Exists Inclined trough
 - 9. Cease IO. Age
 - 11. Article 12. Flaxen fabric
 - 13. View 18. Fall short
 - 20. Haven 23. State

 - 23. State
 24. Nevus
 25. Stop
 26. Leg bone
 27. Explorer
 28. Swelling
 29. Immodest
 31. Yours and mine
 - 33. Bewildered
 - 35. Presentl 36. Tiny bit Presently

- 38. French soldier
- 41. Unfair 43. Pronoun
- 46. Spot 48. Translucent gem
- 49. Attainment
- 51. Increase in size
- 53. Precise 54. Pertaining to a salt
- of hydriodic acid
- 55. Running (suffix) 57. Unctuous liquid 58. Arabian gazelle
- 58. Arabian gazelle 60. Ascended 61. Bone of forearm 63. Her Majesty's Ship 64. Nurse's helper 65. Born 66. Number
- 68. Alcoholics Anonymous 70. Down (prefix)

reminder to student fathers.



L

Unsi, be pi How your

Hi-I

of your column terms starticlub.

be si Fi w sell fideli perio letter the r son woul

So dened interestamp with sell. time.

Letters to the Editor

Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.



Hi-Fi, Anyone?

Permit me to use the facilities of your "Letters to the Editor" column to poll residents and interns across the country about starting a Hi-Fi "swap and shop" club.

The purpose of this club would be simple: those interested in Hi-Fi would be able to trade, buy or sell tapes, records and high-fidelity equipment by means of a periodic, mimeographed newsletter listing such items along with the name and address of the person involved. The newsletter would also bring Hi-Fi enthusiasts together via the mails.

So that no one person is burdened with the expense, those interested should enclose a stamped self-addressed envelope with their list of items to buy or sell. I am ready to start at any time. I would appreciate any suggestions from those interested.

John J. Zadworny, M.D. Chief Resident

COLUMBIA HOSPITAL
COLUMBIA, SOUTH CAROLINA

Contest Answers

As one of those who enjoyed answering the questions in the Mediquiz Contest (although I was not eligible to be an active participant) I am anxious to know the answers since they have not been published. I want to know my mistakes. I am a regular subscriber to the Resident Physician. Could you furnish me with the answers for which I will be greatly obliged.

Milton Wallman, M.D.

FOREST HILLS, NEW YORK

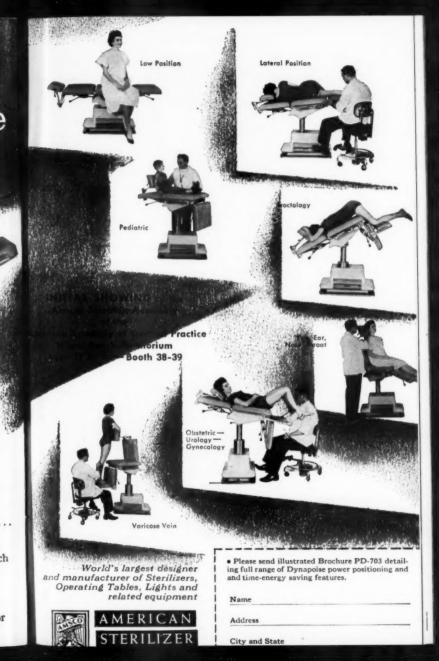
• Answers and references on page 156, this issue.



Unmistakably professional in appearance — without equal in performance, Dynapoise saves time and energy. Its complete versatility of smooth power positioning will enable you to examine and treat MORE patients per office hour. Your patients will be more comfortable, relaxed, and responsive and YOU will be less tired at the end of "hours."

This new powerized Examining and Treatment Table for office and clinic, is a logical projection of the continuing research that produced, and is producing, the world's most favored surgical operating tables.

Dynapoise is clearly destined to become "standard" for modern medical offices. May we suggest that you investigate its physician-oriented advantages . . . now? Mail the coupon for eight-page Brochure PD-703.



-Continued from page 31

Can Do . . .

I read with interest the letter by Dr. Hanson regarding the financial difficulties in providing children with education 'beyond high school. Adding it all up he concludes it is almost impossible to fully provide for your children's education. He asks what to do and then says, "This may well be another area where the government may have to step in." I absolutely have to register a protest to this answer. I think I know some better ones.

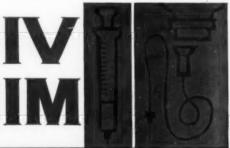
It will take \$10,000 to put

your child through college only if you want it to. Many of my classmates and acquaintances. both boys and girls, went through four years of college for anywhere from 0 to \$4,000 total cost above what they earned before starting college and with part-time work. Some dropped out of school for a vear and saved money to come back. These kids wanted an education. The above is equally true of the additional four years of medical school. Many of my classmates got through on very little money. I never saw one fail to finish because of lack of

-Continued on page 40

Intravenous, vials, 100 mg. (with 250 mg. Vit. Cl, 250 mg. (with 625 mg. Vit. C), 500 mg. (with 1250 mg. Vit. C).

Intramuscular, vials, 100 mg. (with 250 mg. Vit. C), 250 mg. (with 275 mg. Vit. C). (each with procaine HCI 40 mg.) magnesium chloride 46.84 mg.)



ACHROMYCIN Tetracycline Lederle

a standard in parenteral antibiotic therapy

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.



- sure adolesc seling include ern me ceives discree

Nol

Tampritating block to Tampa it does odor o entry of pax does

cal evi



the 'teens-a time of transition

No longer a child, not yet a woman — surely a period of early female adolescence when professional counseling is needed. When the advice includes use of Tampax® — the modern method of protection — she receives reassurance of safe, complete, discreet menstrual hygiene.

nly my es, igh ere ove ing ork. for ome edally ears my very fail

e 40

erle

ysician

Tampax is frictionless and nonirritating. It will not cause erosion or block the menstrual flow. Because Tampax provides internal protection, it does not favor the development of odor or establish a bridge for the entry of pathogenic bacteria. Tampax does afford easy management, easy disposal. And since wide clinical evidence confirms that virginity

is not a contraindication to its use, Tampax is suitable for every age of the menstrual span. Youngsters especially appreciate Tampax at gym and swim time: no encumbrances interfere with activity or cause embarrassment. The older girl favors Tampax because of the social poise it makes possible, despite "the time of the month." Tampax is available in three absorbencies to meet varying requirements.

Why not familiarize yourself now with the facts about Tampax? Its matter-of-fact simplicity, safety and security are just what your teenage patients will be looking for.

Tampax Incorporated, Palmer, Mass.



will you help the mailman, your hospital and us?

May

Resident Physician

Are you planning to move soon?

36

If so, will you please take a few seconds now* to fill out and mail the form below and help us in our efforts to have RESIDENT PHYSICIAN reach you promptly at your new hospital address?

* Please do it now -- it will take us 30 days to process your change of address.

The state of the s	447 14071111611		
Dr		Specialty	
Resident Intern Please check one	Fellow	☐ Clinical ☐ Research ☐ Special	
New Hospital			
New Hospital Street Address			
City	*******	ZoneSta	ite
My chief is Dr. (full name)			
I expect to complete my training here	:	month	vear
Former Hospital Address:			,
Hospital Name		City Ste	te



Why physicians are turning to KORO-FLEX-the arcing contraceptive diaphragm of choice

- 1. Reduces fitting and instructing time.
- 2. Patient ease of insertion-automatic placement.
- 3. Develops patients' confidence. Easy to use.
- Folds behind pubic bone with suction-like action, forming an effective barrier.
- Locks in spermicidal lubricant—delivers it directly under and next to the os uteri.
- May be used where ordinary coil-spring and flat rim diaphragms are indicated.

Recommend: KORO-FLEX Compact, the ONLY compact that provides the arcing diaphragm (60.95 mm) and Koromes killy and cream (trial size). More satisfied patients result from trying both and then selecting the une best suited to physiological requirements. Eliminates guessing. Supplied in feminine clutch-style bag with zipper clusure, Write for literature.

HOLLAND-RANTOS CO., INC. • 145 Hudson Street • New York 13, N. Y

ician

money. One quit for one year but came back and finished.

Or if you genuinely want to spend \$10,000 on each of your children's college education, you almost assuredly can save it if you make the necessary sacrifices. By this I mean cut out the luxuries including a second car. vacation trips to California, etc. I have friends who are school teachers, farmers and laborers. They and their children are making sacrifices and the children are going to college.

These answers are not perfect. And they are not easy. But they are far better than teaching my child to depend on the government to pay his way whether it be educationally or any other way.

L. K. Berryhill, M.D.

IOWA CITY, IOWA

U. of S. A.

I received the February '61 CODY OF RESIDENT PHYSICIAN, with great pleasure, and want to express my sincere appreciation for having received it. I certainly enjoyed reading it again since I returned home from the U.S. in February of this year. I also plan to show it, and encourage reading, to other residents on the staff here. The information in this magazine is always very helpful and surely will be good for us as regards articles and products.

Kindly let me know if I could subscribe to RP regularly. Thank vou in anticipation.

John J. Frick, M.D. PROVINCIAL HOSPITAL

UNION OF SOUTH AFRICA

Service Note

I just received the December 1960 issue of RESIDENT PHYSI-CIAN (overseas). Your article on the doctor draft was quite interesting but may be slightly misleading, particularly where it was stated that doctors having completed residencies would be utilized in their respective field.

I have personally just completed a three year pathology residency; trained in the United States Navy: received my Certificate of Completion and then taken out of the special field and sent to a general duty billet at a very undesirable location, and was not allowed to take my dependents. This gross mismanagement of manpower occurs quite often in all services and is probably one reason no more than the few volunteers do volunteer.

Incidentally, I volunteered and have served in the Navy for five -Concluded on page 50



replaces catheters and enemas

RELIEF FOR THE PATIENT... Prophylactic use of URECHOLINE soon after surgery or childbirth may prevent painful urinary retention and abdominal distention. The appendically, URECHOLINE facilitates micturition and defecation by inducing muscular contractions of the bladder and intestinal tract—without subjecting patients to the discomfort of catheters and enemas.

RELIEF FOR THE PHYSICIAN...By obviating instrumentation, URECHOLINE eliminates the danger of infection that may follow it.

er I-

n r-

S-

as

n-

ti-

gy ed ifien nd t a nd degeiite obthe

five 50 RELIEF FOR THE NURSE... Prophylactic and therapeutic use of URECHOLINE makes scarce nursing time available for other purposes.

Designs Design Design must be individualized. The usual oral design is 10 to 30 mg. Three on four times daily the usual subsultaneous does is 5 mg. (1 (c.) Supplied: Tablets, 5 and 10 mg. bottles of 100 injection; 5 mg. per cc., ampuls of 1 cc.

Before prescribing or administering URECHOLINE, the physician should consult the

MOD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., WEST POINT, PA

years. It is the almost unpredictable and sometimes unreasonable orders or transfers that tend to make even regular officers resign from the service and thus requiring replacements.

C. R. Cotham, M.D. SAN FRANCISCO, CALIFORNIA

Office Equipment

I have noticed a series of articles describing various physical outlines appropriate for the practice of the customary medical specialties depicted in RESIDENT PHYSICIAN. I'm particularly interested in the office layout appropriate for an internist. Either I missed the issue or else, it has not yet appeared in your splendid periodical. I would appreciate either receiving a reprint or an indication of which issue of RESI-

DENT PHYSICIAN that this material has appeared.

Edward J. Brill, M.D. NEWPORT, RHODE ISLAND

• Published in the Oct. 1960 issue; reprint on the way.

Kid Pro Quo

As a kind of delayed rebuttal against those doctors and educators who have written that marriage and children deprive the resident and intern of time he needs for reading, study, and contemplation, I wish to bring to the attention of RP readers the following: of the first eleven winners in the Mediquiz "It Pays to Read" Contest, eight are married and have children. Res Ipsa Loquitur.

NAME WITHHELD
AT WRITER'S REQUEST
ALLSTON, MASSACHUSETTS

ar

tie

m

Ol

th

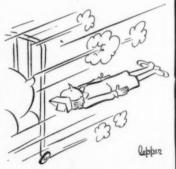
cr al

of fa A pl tic

wi wl

the May 19





Resident Physician

Editor's Page

THE PROBLEM OF FOREIGN MEDICAL GRADUATES

II. Let's Do Something About It!

During the years of this journal's existence, your editor and managing editor have received hundreds of communications from alien foreign medical graduates detailing their medical, and sometimes other experiences and problems in our country. Since the initiation of the examinations given by the Educational Council for Foreign Medical Graduates, critical comment on what is happening in this country to alien foreign medical graduates has increased.

Everyone seems to agree that we must create and maintain a decent and favorable image of our country in the minds of the people of the world, be it the Scot in Holy Loch, the farmer in Laos, or the Baluba tribesman in the Congo. Anything which tarnishes this image or obscures it with platitudes (as certain of the actions related to the examinations of the ECFMG appear to have done) distorts the real image of our country.

We cannot stress too vigorously that we agree completely with the point made by Attorney General Robert Kennedy when he stated that we must make a major effort to educate the young people of the world in our ideals, not only by

).

0

unat ve he nd

to

into

ied

_0-

ELD

EST

2012

ician

bringing them here to study and observe, but also by sending our young people abroad to continue the development and maintenance of the true image of this country.¹ The major effort of the Peace Corps will be directed towards this end. The image of the "Ugly American" must be eliminated!

It has seemed for some time to the Editors of RESIDENT PHYSICIAN that it behooves all of us, our government, what is designated as "organized medicine" (at the AMA, state and county levels), medical educators, the American Hospital Association, and individual physicians, to work out a plan which will absorb into our over-all program of graduate medical education the largest possible number of alien foreign medical graduates. We should do our best, and we don't mean with a lick and a cut, to inculcate not only the scientific and clinical tenets of modern American medicine into our foreign visitors, but also make certain that when they leave us-and their orientation from the beginning must be based on the assumption that they will return to their homeland— they have a clear and convincing image of American culture and of democracy in action. The concept of the "Ugly American" must disappear.

Why? Because experience has shown that in our turbulent and troubled world, ties formed between doctors of medicine in the international scene have been among the firmest, the most rewarding to the individuals concerned, and of paramount value to the people of the countries involved in these international associations. Furthermore, a careful survey of the votes in the United Nations during the past year or so would indicate to all thinking persons that we are not doing too well in convincing the governments of "neutralist" or "uncommitted" nations that our point of view relative to peace and democracy is correct.

There are those, such as Howard K. Smith, who believe

b

b

d

The Great Challenge: "Symposium on International Communism." WCBS-TV, March 5, 1961.

we are in the World War IV, that the battle for the uncommitted countries is on. (It is noteworthy that neither Henry Cabot Lodge nor Robert Kennedy disagreed with Mr. Smith when he made this statement.) There are some who think the Russians are winning because they know they are in it, while we are losing because we don't or won't realize that we are in war. We are permitting one thoughtless blunder after another to obscure the American image in the eyes of the people of other nations. We are just not using our heads. Youth is the crucial group in the world today, and a positive approach to youth is the most important single weapon in the conflict we are in.

What better, more influential Peace Corps could there be than alien foreign medical graduates who have had satisfactory educational, cultural and personal experiences in our country? Each will return to his homeland an ambassador of good will. And if he has had a satisfying graduate education here, the chances are that he will return from time to time for postgraduate work—as a friend of our country and an articulate exponent in his own country of what we stand for.

Perhaps too many of us have been guilty of a narrow view of our own medical manpower situation. We know that our medical schools will graduate but from seven to eight thousand doctors each year. Yet we are disturbed by the situation in our hospitals: more than thirteen thousand intern spaces and nearly thirty-two thousand approved residency spaces—and of these, about ten percent of the internships and nearly fifteen percent of the residency openings remain unfilled. (This in spite of the fact that nearly twenty-five percent of all filled positions are occupied by foreign medical graduates!)

What are the factors which have contributed to this house staff vacuum into which we have pulled foreign medical graduates? The enormous building program for new hospital beds, initiated in 1946-47 by the Hill-Burton Act, and the demands for residency training by veteran physicians between 1946 and 1950 were important in creating a deficit of house staff.

ysician

In the past ten years, the number of approved internships has increased by twenty-five percent, while residency spaces have increased by some fifty percent. It seems reasonable to assume that with the continuing growth of our population, the number of house staff spaces will further increase as more hospital beds come into being, and especially as the steady trend towards residency training by more and more graduates does not seem to be diminishing.

It is not our purpose to criticize the alien foreign medical graduate training programs in the U.S. in toto. Some alien foreign graduates have received excellent graduate medical education in the best hospitals in the U.S. And many of our foreign graduates are aware and deeply appreciative of the extra time and special attention given them by their chiefs and American house staff colleagues in our hospitals. There are some, however, who have found themselves unwittingly utilized in U.S. hospital "training programs" whose levels of "education" and "supervision" were so gravely deficient as to be a mockery and an insult to what is considered good graduate education in this country. In short, the alien medical graduate, far from being viewed as the challenge and opportunity he represents, has on occasion been deceived, exploited, insulted, and short-changed by hospitals having neither the facilities, the staff, nor professional training programs capable of serving his patient service needs and educational interests.

The spirit of the Exchange Visitors Program is being eroded. The too liberal policy of the Council on Medical Education and Hospitals over the years in approving residency programs, in our opinion, has meant that too many openings which exist are essentially in "paper" residency programs for which Council approval has been continued over the years.

Finally, let us see what the magnitude of the educational problem for alien doctors might be. Up until August 15, 1960, a total of 12,011 foreign graduates had taken the qualifying examination of the ECFMG. Of these, 4,705 candidates "passed" (scores of 75% or higher); 2,768 candidates nearly

S

a

h

th

cl

passed (scores 70%-74%) and were issued Temporary (two-year) Certificates, while 4,538 or 31.8% failed. Thus it seems likely that each year, if the numbers examined remain constant, about one-third or between two thousand to twenty-five hundred alien foreign medical graduates will fail the examination.

Now these individuals should be a matter of concern, not only to our government, but to every medical educator, medical administrator, hospital administrator, and physician in our country.

Suppose, and this is already taking place, each of these two or more thousand graduates accepts the hospitality and graduate educational facilities of the USSR or its satellite countries? We know Russia and its allies are doing their best to attract students. Think what an internal force among the intelligentsia of the "neutralist" and "uncommitted" countries this group might turn out to be! We may well be converting two thousand of potential friends to bitter critics of our way of life!

Now, what can be done about this situation? RESIDENT PHYSICIAN makes the following suggestions:

I. The ECFMG should assume additional functions to that of giving a qualifying examination:

 Become the advisory body on foreign medical education in general, and on the existing situation in individual foreign schools in particular.

• Create a central pool of information relative to 1) house staff positions which are vacant in various accredited hospitals, and 2) alien foreign medical graduates who are looking for house staff positions. (Let this Council really concern itself with the problems of foreign medical graduates while they are in our country.)

• Re-evaluate the type of examination which it gives. In the March issue of HARPER's magazine, Banesh Hoffmann reports a critical study which he has made of the multiplechoice type of examination. He finds them wanting in many respects. As he points out, the examinee of exceptional ability may fail the test because he is a "statistical misfit in an

rsician

age of mechanized judgment." Certainly the ECFMG should be concerned with defects in their system of examination! Medical educators should shoulder their responsibility in this regard, not slough it off.

II. The Council on Medical Education and Hospitals should keep a stricter eye on intern and residency training and educational programs through two devices:

• Properly constructed annual questionnaires to all interns and residents in approved programs relative to the educational aspects and value of these programs.²

• Unannounced spot visits and inspections of Councilapproved, graduate educational programs by qualified consultants to the Council.

III. The Association of American Medical Colleges, in whose sphere graduate education and training properly falls, should assume a position of dynamic leadership in this field, especially in the field of graduate medical educational programming—something that it has not done to any appreciable degree. (The AAMC has deferred to the Council on Medical Education and Hospitals, a body which in the past has not taken a very active interest in methods or programming of graduate medical education, but rather has left that activity to chiefs of approved services.)

IV. The AAMC should make certain that no hiatus is permitted to develop between undergraduate and graduate education, and redouble its efforts to improve educational practices in the graduate and postgraduate fields.

V. The Federal Government, probably through the NIH of the Department of Health, Education and Welfare, and possibly the State Department, should assume the responsi-

bil

of

sel

pre

WC

op

car

OV

gra

be

an

the

for

EC

ha

gra

be

a

in

to

pa

the

or

be

ha

OW

po

alı

the

^{2.} The results of a questionnaire sent to 4,000 house staff members by Resident Physician (March 1960) indicated that about one quarter of the educational programs approved by the Council on Medical Education and Hospitals were considered unsatisfactory by participants in the programs.

bility for directing the external organization and financing of the programs developed by the ECFMG and AAMC in selected medical educational centers for the purpose of providing in the United States at least one year of practical work in the basic and clinical sciences and in English. This opportunity for special training would be awarded to those candidates who initially do not make a passing mark in the overseas examinations of the ECFMG. Alien foreign medical graduates, after at least one year in this program, would then be reclassified on the basis of the evaluation of their basic and clinical science instructors who supervised them during the year. Those classified as satisfactory would be eligible for hospital appointments through channels developed by the ECFMG; those who were not, would return home having had a full year of valuable experience in our country.

Under such a plan, there would be no initial ECFMG grading of "passed" or "failed." Rather the candidate would be notified that he was eligible for a year of schooling or for a hospital appointment. All would have at least one year

in this country.

"Near pass" and "failed" are too harsh words to be applied to intellectual capabilities of foreign graduates from many parts of the world, especially those from countries in which the concept of the "learned professions" has just been revived or is of a relatively recent origin. There is no excuse for being rude and insulting to our colleagues who are trying so hard to pattern their professional life after the image of our own.

And there is even less excuse for prolonging and compounding those elements of the present program which have already embittered thousands of young doctors throughout the world.

Perin H. Long,

ian

CPC-manship:

The Not-So-Gentlert Case Presentation

Sidney Fink, M.D.

Day after day, residents present cases to other MDs, usually at the bedside, often in conference rooms and occasionally in large amphitheatres. These conferences give each resident an opportunity to assess clinical problems—to present his views to a captive audience. This too is a time when his seniors can make their assessment of his progress and abilities.

When you are "acting toastmaster" at sessions where a patient is presented to your audience, always remember that the patient is the most important individual present. Even the most egotistical Think Do y Are Do y

of en

chief of an attitu spect fo the pro good me coopera

1. Le coming sons for time. (S her hair by not hurse j





Think, for a minute, about your conference "image."

Do you look and sound your best?

Are your colleagues apt to find the hour worth while?

Do your patients get maximum benefit from their ordeal of exposure?

chief of service will approve of an attitude which shows equal respect for him and the man under the probe. A protocol which is good medicine and enlists patient cooperation is as follows:

re-

lly

in

p-

ob-

) a

a

ike

ess

as-

ent

al-

t is

ual ical I. Let the patient know of the coming conference and the reasons for it. Include the day and time. (She may want to put up her hair, and will further oblige by not accepting an enema from turse just before curtain time.)

Key attendings should be prompt. There is seldom any valid excuse to keep the patient waiting.

3. Rumor has it that a few years ago one of the candidates taking Part II of the Internal Medicine Boards was failed for not introducing the patient to the examiners. Always show your respect for the patient by introducing the doctors (if four or less are present) or a senior member

of the audience, before beginning an examination.

4. At the end of a conference, be sure to thank the patient directly, and tell her when you will see her to translate the jargon.

During bedside presentation, be careful to avoid the three sins embodied in the word "rude:" 1) rocking the bed, 2) careless terminology, 3) entertaining the rest of the ward.

Impression

At a conference, remember that frequently the impression a speaker makes is based much more upon his opening and closing remarks than upon the body of his talk. (Cynics say: "Your colleagues come for entertainment, not to be confused with facts.") Show that you consider your colleagues' time valuable by beginning with a concise opening sentence, one which gets immediately to the heart of the problem. This is much better than launching broadly into a case history without first letting your colleagues know what questions will be asked of them at the end. Similarly, if the patient is being presented solely to introduce a general discussion of a particular medical topic, begin by saying why you chose this case. For example, "Mr. Jones is being presented as an example of the ef- new boo fects of I131 therapy for this con- how to dition." Do you remember the (Unfor questions after your last presen- anythin tation? If the doctors asked you At t for facts given in the history, your stop the initial briefing was not sufficient- early as ly explicit, or worse, you mum- dations bled the presentation of data them. (Distribution of mimeographed one of copies of a rundown of history dience and lab studies is usually effection. The tive, saving time and confusion because at the conference.)

Anecdotes

It is rarely a sound procedure turing, to begin lectures with anecdotes, for a q especially if the patient is present final s or if you are speaking to a group points. senior to you. Actually, the number of outstanding medical stories is so limited that your attending have probably heard them many find that times and will bless you if you helps th save them another recounting.

On the other hand, if you are own lar going to speak to medical stu- and che dents or to a group of your These of peers, they will appreciate a new able w anecdote, well told. (After all, camera the anecdote may be the only trips v thing they will remember!)

I recall a speaker on new heme theories of insulin action, who approxi still preferred the old theories. When Aussie bushman who liked his em in

future : a defini out into

Visual

Even It is no point p

ef. new boomerang "but didn't know con- how to throw away the old one!" the Unfortunately, I don't remember esen- anything else he said.)

At the end of your sessions, your stop the discussion a few minutes ient- early and sum up the recommennum- dations of the group as you see data them. You may even wake up phed one of the senior men in the austow dience by asking a direct queseffection. This is a good step not only usion because it practically assures his future attention, but it gives you a definite opinion which may be put into the chart. If you are lecedure turing, always leave enough time lotes. for a question period and for a esent final summary of the cardinal roup points.

num-Visual aids

Even the most fluent speakers many find that what an audience sees you helps them retain what they hear. It is now possible to make your u are own lantern slides quickly, easily stu- and cheaply using "Radio-Mats." your These cellophane strips are availnew able with glass slides at large r all, camera stores. By writing on the only strips with a typewriter or ballpoint pen, you can illustrate any new theme and project it at a cost of who improximately five cents per slide.

Whether using "Radio-Mats" of the or a blackboard, the main probd his em in visual aids is to avoid writing too much in too small a space. Always list highlights, and nothing else. Three or four words printed in capital letters provide a much firmer scaffold on which to place your story than a tangle of dates, symptoms and laboratory data. Automobile reflector tape, cut into small squares, provides a luminescent marker on the right upper corner of your slides.

Finally, and most important of all, be sure that the projectionist knows how to use the machine. and the order in which to use your slides. If you don't have a spare projector bulb, get one! Also, get a long pointer to help focus the attention of your listeners.



Vou

tories dings g.

ories.

A slow speaker bores his audience; a rapid speaker loses them. If you have a friend who is willing to give you an objective evaluation, ask him for constructive criticism of your delivery. Less ego-traumatic, perhaps, would be the use of a hospital dictating machine. (Despite the influx of English secretaries, these machines are available in almost all hospitals and provide you with a chance to hear vourself as others do.)

Approach

We are left with one special conference, the CPC. Since every hospital must hold a minimum number to keep its accreditation, you have undoubtedly been exposed to these whodunits. If your hospital mimeographs the cases, make your presentation a "short and sweet" capsule report. This will endear you to the clinician and the pathologist, both of whom will be staring at the clock from the minute you step up front. If you are the discussor, choose the approach best suited to your temperament:

1. The Captain of Medicine of empire-builder approach: Begin by giving your diagnosis, and confidently marshall all the facts. It the final three minutes, briefly list and dismiss the alternatives This approach is very impressive if you are right, devastating i not. Recommended only if you are very bright, saw the autopsy report, or know the pathologist's favorite diagnosis.

2. The Grey Flannel Suit of conservative approach: Begin by listing every possible diagnosis and as you reluctantly rule each one out, keep the audience guess ing. When you do make a final choice, pick a common condition Even if you are wrong, your repu tation will be upheld by sud comments as "he thought everything but was practical (Rule: better wrong with appea dicitis than wrong with porphy ria!)

3. The Straddle or ultra-con risk-no-prestige servative, proach: Begin by listing the three or four main possibilities. Give a scholarly dissertation on each showing why each is very likely

The author completed residency training in 1958 and ABOUT now the gastroenterologist with The Paterson Clinic THE AUTHOR New Jersey. His current contacts with "CPC-manship" at through the house staffers at Barnert Memorial Hospita and Columbia-Presbyterian Medical Center.

Then broad will b diagno cians ' ing th here is thing If you cussio upbrai or ac vourse Kodac

Popula

For approa keep a

Then sit down. Unless your broadside missed completely, you will be credited with a correct . diagnosis, and only a few clinicians will accuse you of not "playing the game." The only danger here is that you must leave something for the pathologist to say. If you preempt him in your discussion, he may be piqued and upbraid you for being indefinite, or actually make you commit vourself before he shows the Kodachromes!

Popular

01

gir

on-

. In

iefli

ves

siv

gi

you

opsv

gist's

it or

n by

osis.

each

uess

final

repusud sud nt dical' ppen rphy

1-CON

three

each

likely

and

inic i nip" at Tospit

hysicia

Fortunately, no matter which approach you choose, you can keep a few blots off your escutcheon by 1) having enough friends appear on time so that you shatter tradition by beginning promptly 2) wearing a uniform unstained by Topfer's or Gram's iodine 3) speaking loud and clear 4) being brief.

Even these rules have a danger, however. By following them, you will be so popular, regardless of your diagnosis, that you may be asked to enter the lion pit again!!

After residency, you will spend less time talking and more time listening. This is an even harder role to play properly, and (fortunately for you) can be left to publication in some future journal for "The Attending Physician."

MEDICAL REPORT

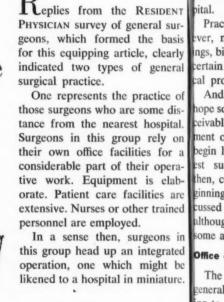
Of germs and such I don't know much
But a virus, like as not,
Is what most people say they have
When they don't know what they've got.

STEPHEN SCHLITZER

Equipping the

Surgeon's

Office



The urgeor espone office 1 opposit ittle su surgery

bital. Prac ever. r ngs, bi cal pro

And hope so ceivabl ment c begin 1 est su then, c ginning cussed althoug some a

Office

The general ing to one of First is for its tional design. prinkl

May 196

The second group of general urgeons, a majority of surgeons esponding to the survey, have office facilities which lie at the opposite end of the scale. Very ittle surgery is done in their ofices. In the extreme case, no urgery at all is done "on premses"-but is taken to the hospital.

Practically all surgeons, however, make provision for dressarly lings, biopsies, suture removal and certain so called "minor" surgical procedures.

And though the resident may hope some day to have every conceivable kind of surgical equipment on hand, generally he will begin his practice in more modest surroundings. This article, hen, concerns itself with the beginning practice. Most items disined cussed are of a "must" varietyalthough mention will be made of some added starters.

Office decor

ENT

sur-

asis

eral

e of

dis-

ital.

on

or a

era-

lab-

are

s in

ated

t be

ture.

sician

The design and decor of the general surgeon's office, according to our survey, fits itself into one of two distinct categories. First is the "aseptic" type, notable for its "hospital look." Equipment and furnishings are functional in appearance as well as design. Furnishings are liberally sprinkled with stainless steel and chrome over white enamel. Few embellishments or decorations. simply for the sake of decoration, are visible. The atmosphere is one of business-like efficiency.

The second class of furnishings and appearance, becoming more popular in recent years, is what might be described as the casual, warm type and presenting a homelike and relaxed atmosphere. Color and texture in drapes and carpeting is inviting and appealing to the eye. Natural woods, colored plastics and upholstery are evident in both furniture and accessories.

Preference

Even the examining room may carry through with this "living room atmosphere" and the equipment is often mahogany, tan or pastel in color, but not white.

Selection of either a "home" or "hospital" decor, as well as the specific furnishings, is best left to the surgeon's own preference. Both are attractive. Each offers advantages and disadvantages, many of which are more aesthetic than practical.

Generally speaking, the "hospital" decor is less expensive to attain and maintain.

Although similar to that of many specialists, the surgeon's waiting room requires added

Office equipment you'll need in private practice

This is the ninth in a series of exclusive articles on equipping your office for the private practice of your specialty. It is based solely on a survey conducted by your journal among practicing specialists. Prices quoted are approximate and represent new equipment unless stated to the contrary. When a wide range of price and quality is available for a specific item, this fact is indicated.

consideration on two points concerning his patients. The waiting room should be comfortable and completely restful in its atmosphere. Very often the surgical patient, both pre-op and post-op, is apprehensive and tense. Much can be done in the choice of color and texture to make the waiting room soothing and relaxing. Gaudy and garish design, even in minor decorations, is to be avoided. Lighting should be bright but shaded adequately to prevent glare and promote com-

fort. (Many surgeons stressed this point.)

The size of the waiting room should allow for the fact that many surgical patients are accompanied or assisted to the surgeon's office. The average waiting room of those surgeons responding to the survey made provision for seating six to ten individuals.

Chairs, floor covering

As revealed in our survey, the most common type of waiting room chair is plastic-covered wood or metal. This was chosen because it was "economical, attractive and easy to maintain." The number of chairs, of course, depends upon the size of the waiting room; prices of chairs ranged from \$25 to \$40, according to general surgeons queried.

The waiting room floor was carpeted in 40% of the offices of surgeons interviewed. Price of the carpet including underpad varied from \$8 to \$12 per square yard installed. About 10% had the floor of the waiting room covered with rubber tile; 35% had some form of plastic tile. The average cost of floor covering was \$400 for the entire office.

A few comments were: "rubber tile and cork is quieter and softer," plastic tile "is cheaper and e "carp to a l

The tion is table ported (Price

Tal

and n

tained \$40 c present quant size. for m avera your to look p geon's

Const

The room fortabit neclength portar special course the degeons drawe to kee cabine drawe

A g

and easier to take care of," and "carpeting is dignified and adds to a homelike feeling."

sed

om hat

ac-

ur-

ait-

re-

TO-

ndi-

the

ing

red

sen

at-

in."

rse.

ait-

ged

to

was

ices

e of

pad

are

had

moc

5%

The

ring

fice.

rub-

and

aper

ician

The lamps chosen for illumination in the majority of cases were table lamps and the average reported cost was \$35 per lamp. (Prices ranged from \$20 to \$55.)

Tables are required for lamps and magazines. These can be obtained for no more than \$30 to \$40 each. Ashtrays should be present in the waiting room "in quantity" and be of sufficient size. "Used by heavy smokers for more than thirty minutes, the average ashtray will overflow—your furniture and rugs will soon look pretty awful," was one surgeon's comment.

Consultation room

The surgeon's consultation room should be roomy and comfortable. The surgeon often finds it necessary to take a rather lengthy history and comfort is important. The desk presents no special problem. It should, of course, be kept in harmony with the decor of the room. Many surgeons are of the massive, multidrawer desk school; others prefer to keep papers and forms in a cabinet and use a small one-drawer desk for history taking, etc.

A good desk can be purchased

for as little as \$90. "But it's easy to find one for \$500 if you have nothing better to do with your money," said one surgeon.

Average price paid by our responding surgeons was under \$200.

The desk may or may not require a lamp of some sort. If one is chosen it should be chosen with the thought in mind that it should illuminate only the desk surface—not get in the patient's eyes. A good desk lamp may be purchased for under \$50.

The surgeon (as most specialists) can profitably devote special consideration to his own desk chair. "Get one to fit — you'll spend plenty of hours in it..." advises one surgeon. The average price quoted for such a chair was from \$90 to \$150.

Two additional chairs should be in the room, one for the patient and one for a relative or friend. These chairs are less expensive and should certainly cost no more than \$75 each. Some surgeons reported having a couch in this consultation room (usually covered with leather or plastic). Such a couch can be purchased for a price of between \$150 and \$250.

The decoration of the consultation room should be restrained and dignified. Diplomas and credentials should be attractively framed. "They are decorative and impressive" and "give the patient tangible evidence that his confidence in the surgeon is well-placed," was one surgeon's comment.

Bookcases are needed. These should be attractive as well as functional and in harmony with other furniture in the room. They need not be expensive to be well constructed.

Examining room

The examining room in a surgeon's office usually contains an examining table, a treatment stand, a treatment cabinet, and a good lighting arrangement. The surgeons may have another room for minor surgery.

In general, the examining table should be sturdy and should either be adjustable in height or have a step stool for the patient. An electrical outlet is a convenient accessory.

An examining table can be bought new at prices from \$200 to \$800. Secondhand tables may be obtained in some localities for a price as low as \$75 plus extra for repainting and conditioning (\$10-25).

Operating tables were reported by 20% of the surgeons interviewed. Many of these surgeons were in areas far from hospitals. Tables were primarily of the "hospital" type, are adjustable to a number of different positions which the surgeon requires in his operating procedures. The cost of these tables varied from \$800 to \$1200 and more, according to respondents.

Treatment stands and cabinets, necessary to hold instruments and other apparatus, can be purchased for \$75 to \$200.

Some method of instrument sterilization is needed. Nearly 40% of our survey respondents reported they had an autoclave in their offices; the average price given was \$250 to \$300. The remainder of surgeons responding used conventional water sterilizers. Prices here were generally under \$75.

Special equipment

Three out of ten surgeons stated they used a diathermy machine in their offices. Surgeons in this group reported a large compensation practice. The price of diathermy equipment is \$700 to \$800. Roughly 20% of the responding surgeons had an ultrasonic apparatus; reported costs ran around \$500.

BMR equipment was present in 25% of the offices surveyed. Those who had such an apparatus admit tice b in thy indica of suc ably c tion i This

A surged \$250 second

Min drugs office than to our

Illu

light soffers and coof a solow \$200 The

not the "necessing geon." cases dicate tice cases

Other

Oth depen geon. added

May 1

admitted it was used in their practice because they were interested in thyroid procedures; but they indicated that the added expense of such equipment would probably eliminate it from consideration in the beginning practice. This apparatus costs from \$400 to \$700.

e

S

is

st

0

0

S,

d

d

nt

ly

ts

ve

ce

e-

ng

2-

ly

ns

a-

ns

ge

ce

00

he

a-

sts

ent

ed.

us

ian

A microscope is part of the surgeon's equipment and will cost \$250 or more new or \$175 secondhand.

Minor surgical instruments and drugs needed to stock the new office usually average no more than \$200 combined, according to our survey.

Illumination in this room is extremely important; the type of light selected should be one that offers a bright, shadowless light and can be focused. The price of a suitable light varies from a low \$25 to a high of about \$250.

The majority of surgeons did not think an x-ray machine was "necessary for the beginning surgeon." One reported: "The few cases where an x-ray may be indicated in the early years of practice can easily be referred."

Other instruments

Other instruments needed will depend upon the individual surgeon. A sigmoidoscope may be added to the list if this procedure is to be done in the surgeon's office, a bronchoscope, too, may be added.

In many surgeon's offices there is an extra room, a "utility room." It may consist of a small laboratory, a place to clean and sterilize instruments and gloves, perhaps a small table where the patient can receive diathermy therapy. Laboratory equipment needed for the general surgeon in the beginning, that is equipment sufficient to do blood counts, sedimentation rates and urines, should cost no more than \$35 to \$50. A simple upright, rigid table where patients can receive ultrasonic or diathermy therapy can cost as little as \$50.

A big item and one which may be needed in some localities is anesthesia equipment. Most surgeons in large cities reported they did not prefer to give general anesthesia in the office, feeling that such cases "should be operated on in the hospital." In smaller localities some surgeons find it necessary to have this equipment in their office.

Many surgeons used electric cautery in their first year, some 60% of the interviewed surgeons. Such an apparatus, of sufficient size and intensity to accomplish the work required may cost as much as \$350.

As dressing rooms are used so frequently, special care should be taken in furnishing them. The dressing room should be separated from the lavatory and adjacent to the examining room. It should be well-lighted, have a seat and a mirror. Hangers and hooks should be supplied for clothing and gowns. The door should be able to be locked from within. The total cost of dressing room equipment is usually under \$100.

The lavatory, aside from being readily available to both the waiting room and the examining room, should contain a wash bowl, stool, a mirror, shelf, waste basket, soap and towels. Your nurse will have access to sanitary items and will make this known to each patient.

AR

CL Coo Cli: Geo Sch Radiolo AL Att Patholo VE

Ass

HE Sen WF

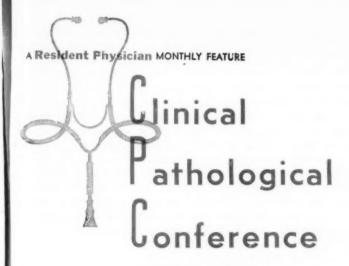
May 196

In summary, the total cost of office equipment of those responding to the RESIDENT PHYSICIAN survey ranged from a low of \$2300 to a bit over \$5000.



"See . . what did I tell you? It's all in his mind."

Resident Physician



Washington Hospital Center, Washington, D. C.

Discussant:

ig t-

ng sh te

ur ry vn

of ey-

> CLAYTON B. ETHRIDGE, M.D. Consultant in Medicine, WHC; Clinical Professor of Medicine, George Washington University School of Medicine

Radiologist:

ALBERT J. MIELE, M.D. Attending Radiologist, WHC

Pathologists:

ian

VERNON E. MARTENS, M.D. Director of Laboratories, WHC; Associate Professor of Clinical Pathology, Georgetown University School of Medicine

HENRY W. EDMONDS, M.D.
Senior Attending Pathologist,
WHC

R. CLAYTON B. ETHRIDGE: We are here dealing with a 40year-old waitress. Five months prior to her admission she had urinary symptoms which a physician told her represented "kidney trouble." He treated her with an injection and some pills. Four months prior to her admission she developed a cough, productive of some vellowish-white sputum. Along with this she began to have day chills and night sweats, which suggest that she had a septic type of temperature declining at night and rising during the day. She also had other symptoms during the interval prior to admission; general aches and pains, backache, and loss of weight.

She noticed there were some spots on her skin; also she had some blurring of vision with double vision, and noises in her ears, for about one month prior to admission. The cough, poor appetite, muscle and joint tenderness continued; and she also had tenderness at the tips of fingers.

In addition she had some abdominal distention, and about one week or two prior to her admission here, she began to develop shortness of breath, and then orthopnea and paroxysmal nocturnal dyspnea, plus ankle edema and abdominal distention. The additional information that we have in the past history states that she drank six beers a day.

She had lost 35 pounds in weight according to the history and on admission weighed 145 pounds. She had a fever, 103.4°; pulse 120; blood pressure 130/60. She was stated to be well nourished and well developed, despite the loss of weight, but was dyspneic with respirations of 36. Fundoscopic examination showed a flame-shaped hemorrhage in the right eye. There were bilateral moist rales, presumably basal in the chest. In

the heart there was tachycardia and a Grade I systolic and diastolic murmurs.

The Grade I systolic may not be significant, but any grade diastolic murmur is significant. Therefore, in view of this diastolic murmur, we can say that this patient had some form of cardiovascular disease. It was heard loudest at the base, in the aortic area, and there was radiation to the neck, but no thrill. It is stated that there was no cardiomegaly by physical examination at that time.

Edema

The abdomen was distended and tender in both upper quadrants. The liver was enlarged to the right iliac crest. The spleen palpable, three fingerbreadths below the left costal Costovertebral margin. angle tenderness was not present. There was 4+ sacral edema and 2+ ankle edema. The skin showed spiders. This would multiple suggest the possibility of cirrhosis of the liver or at least impairment of liver function as a basic condition; but certainly that is not her principal disease. There was no jaundice, no enlarged lymph nodes, and minimal clubbing of the fingers.

I think so far, we are entitled

to mal on this point. pressed up to b or suba endoca short weeks betwee terial ence is acute a less vii althoug lap to their n

have e four of label t endoca at least aortic sufficie insuffice blood not of This

matolo

haystac grown of seve bacteria

It is tient d subacur

May 196

to make an admission diagnosis on this patient. I do so at this point, and certainly I am impressed that the findings here add up to bacterial endocarditis, acute or subacute. By definition, acute endocarditis is supposed to be short-lived if untreated. weeks is perhaps the dividing line between acute and subacute bacterial endocarditis. The difference is that the organisms of subacute are a little less active and less virulent, generally speaking, although these diseases can overlap to a considerable extent in their manifestations and symptomatology.

dia

as-

not

di-

nt.

pa-

io-

ard rtic

to ted

alv

hat

ded

ad-

to

een

er-

stal

ere

2+

ved

uld cir-

east

as

ise.

enmal

iled

Because the illness seems to have evolved over a period of four or five months, I would label this as subacute bacterial endocarditis, and at the moment at least, with involvement of the aortic valve, producing aortic insufficiency. Her degree of aortic insufficiency, judging from the blood pressure of 130/60, was not of a highly striking degree.

This causes me to wonder a little bit where the needle in the haystack is here, because she has grown seriously ill over a period of several months from subacute bacterial endocarditis.

It is fairly unusual for the patient during the acute phase of subacute bacterial endocarditis to have serious heart failure. I begin to suspect that there is more to this than the pure septic aspect of subacute bacterial endocarditis and the relatively meager findings of aortic insufficiency, that is, a Grade I diastolic murmur. However, there is enough here to suggest that the aortic valve is involved. I rather suspect that something else is involved to explain the rather severe degree of right heart failure. There was left heart failure, here from the symptomatology, but from the physical findings there was obviously also right heart failure, and this is surprising for a minimal degree of aortic insufficiency over a short period of time.

Multiple involvement

These are admission thoughts, shall we say. On the basis of what we have yet in the protocol, we will probably have to modify these thoughts as we deal with the hospital course. What is impressive about the symptoms and signs of this patient's disease, is that there is multiple system involvement. We have evidence in the diplopia, etc., of some involvement of the brain. We have obvious evidence of some involvement of the heart, namely aortic insufficiency. We have evidence of congestive heart failure,

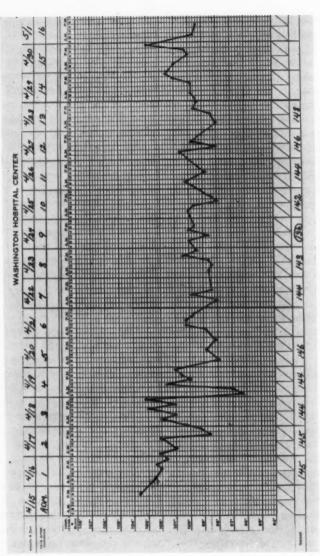


FIG. 1. PATIENT'S TEMPERATURE AND WEIGHT WHILE IN HOSPITAL.

certain had any it migh of wha wonder have be tor, nat came I rather and en

involver perhaps suggest

Manife
So winvolving fever (a passing this concerpthen tem invitainly, erythen peculia tainly usual from fever, cardial rare in much coproblem make the endocard I want that the soft soft some content of the content o

May 196

vsician

involvement of the lung, with perhaps an antecedent history to suggest kidney infection. It is not certain whether the renal disease had anything to do with this, but it might have been the inception of what came later. We also wonder whether the cough might have been related as a causal factor, namely pneumonia, in what came later. There was also a rather striking liver involvement and enlargement of the spleen.

Manifestations

So we deal here with diseases involving multiple systems with fever (Fig. 1). One might give a passing thought as to whether this could be a disease like lupus erythematosus with multiple system involvement and fever. Certainly, acute disseminated lupus erythematosus does have many peculiar manifestations. It certainly would, however, be unusual for it to produce the murmur of aortic insufficiency. However, cardiac involvement (pericardial and myocardial) is not rare in lupus; and yet there is too much other evidence to take the problem out of that realm, and to make the diagnosis of bacterial endocarditis more likely.

I want especially to emphasize that there was soreness in the tips of the fingers. There are Osler's nodes which, while not absolutely pathognomonic of bacterial endocarditis, are most commonly seen in this condition. We also have a flame-shaped hemorrhage in the eye which is suggestive of bacterial endocarditis.

We also have to think whether something like Hodgkin's disease could produce all of these things. I would say no, although it might produce a febrile course and multiple system involvement. I feel this was certainly a patient with bacterial endocarditis, probably particularly involving the aortic valve, but with clear manifestations of right heart failure.

We shall see what the laboratory studies and the hospital course brought forth to clarify this diagnosis. We might run through the hospital course rather briefly and then we will get to the laboratory studies.

The patient was placed on treatment for heart failure, namely low salt diet and diuretics. The heart murmur was stated during the first day to be a little louder, namely, a systolic Grade II, diastolic Grade II, noted at the base. Penicillin was started, along with streptomycin, in fairly sizable amounts; digitalization was begun and continued. Then we ran into a rather striking thing, at least to me; venous pres-

sure 140 mm and circulation time (arm to tongue) of 15 to 18 seconds.

Certainly I thought the venous pressure should be much higher than this from the physical findings and the degree of symptoms; and certainly the circulation time I would suspect would be longer than this. This surprises me and makes me feel that there is something strange in respect to this particular disease that makes these things possible.

Course

On the sixth day her weight remained approximately the same and she was still in heart failure. Blood pressure was 136/40 (the diastolic pressure is dropping). Heart sounds remained unchanged. On the ninth day, the fingertips became tender. Here again we have another shower of what appears to be Osler's nodes consistent with the diagnosis of bacterial endocarditis. There was noted also a discoloration of the pads of the right middle and left ring fingers. Congestive failure was worse, gallop rhythm had developed, the pulse was still up (108) and on that day there was severe pain in the left upper quadrant. The spleen was enlarged and very tender. This would suggest a splenic infarction.

On the eleventh day clubbing blood s of the fingers was more marked moderat and the patient seemed worse. gms, as Blood pressure was 122/20 (the There w diastolic pressure was dropping and a to further). Diastolic gallop was it is into present and the heart was now sosinopl enlarged (previously it was stated his deg not to be enlarged). Therefore, vas, ho things were moving fast here, ad-lolymor versely for the patient.

On the thirteenth day she was btal wh critically ill and disoriented Digitalis was increased. On the fourteenth day, rather surprisingly, there was a sudden loss of on stu a great deal of fluid (3 liters) ery stri and the patient seemed improved. not i Murmurs were now loudest at ever dis the apex of the heart. She was ather s given 250 cc of packed red cells. ause it However, on the fifteenth day Certainly peripheral cyanosis, bronchial ire that obstruction, and death occurred BSP Though she had been in the hos- cannot pital only about fifteen days, she lignificant had been ill four and one-half to the migh five months; and now she is dead dirrhosis

Now for the laboratory studies. Len Berg The urinalysis gives white cells um show and red cells as being found, but loccus a it does not indicate whether albu- These a minuria was present and to what portant. extent (there was no albumin in flown (4 the urine on the fifth and tenth be surprised hospital days; there was 10 to the e mg% albumin on the twelfth and eactive fourteenth hospital days). The his is pr

rease in

tudies

Next

oing blood studies showed a rather ked moderate anemia: hemoglobin, 9 rse. ems, and hematocrit, 31.5%. the There were seven percent bands oing and a total PMN count of 83%. was It is interesting that she had one now osinophile which is unusual in ated his degree of infection. There ore, was, however, an increase in ad-lolymorphonuclears and an inrease in band cells, although the otal white count was not high. Was

tudies

ited.

the

pris-

rred.

Next we have some liver funcis of on studies: thymol 6.1, not ers) ery striking; BSP, 19.5%. This wed not interpretable as primary t at ever disease in the presence of was ather severe heart failure, becells, ause it could be due to either. day Certainly the degree of heart failchial re that she had could produce BSP of 19.5% retention. So. cannot interpret that as being hosshe ignificant evidence of whether If to the might have had an underlying lead irrhosis of the liver. The van dies. Jen Bergh was not striking. Spucells um showed some alpha, strepto-, but occus and Neisseria catarrhalis. albu- These are not particularly imwhat portant. Prothrombin time was in in lown (42%). This would not tenth se surprising in liver involvement 10 to the extent that she had. Cand eactive protein was positive; The his is purely evidence of inflammation in the body. ASO titre, 125, perhaps significant, perhaps not. BUN was 12.5 mg%.

I regard this as significant together with the absence of albumin, since in bacterial endocarditis, particularly subacute, the kidneys can be affected in various ways. There can be septic emboli of the kidneys with development of the so-called "fleabitten kidnevs." They can be the seat of a larger infarction, which can impair function and produce pain and red cells and white cells in the urine. Interestingly, subacute bacterial endocarditis is one of the causes for acute secondary disseminated glomerulonephritis. So, some of these patients might present with a fair degree of nephritis.

The SGOT or transaminase was 170, way up! This is interesting because once again its basic cause is not clear to me; whether this represents involvement of the liver, and the enzyme is being released from the liver because of perhaps pre-existing liver disease. The patient was not jaundiced, however.

In addition, the heart may be the seat of myocarditis secondary to tiny emboli. We should recognize also that occasionally in bacterial endocarditis there may be a larger embolus that goes into

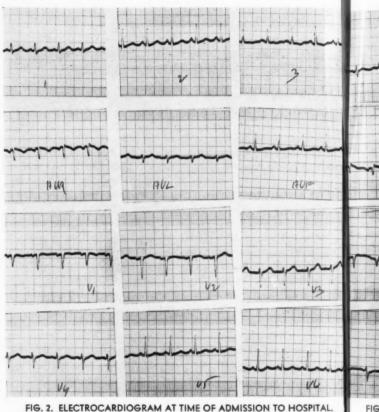


FIG. 2. ELECTROCARDIOGRAM AT TIME OF ADMISSION TO HOSPITAL.

the coronary vessels; so that there can be concomitant acute myocardial infarction from an embolus. But I don't believe that the latter took place. We will talk about the electrocardiograms in a minute. But the SGOT or transaminase is definitely abnormal and may represent variou inin 2.9 things: liver, heart, lungs-at the most st moment I do not choose to in min is particul terpret it specifically.

Urinalysis showed many realisease cells and 10 mg% albumin or in to be the first of May, the day she died oumin is The total protein was 5.6, albu I can



FIG. 3. ELECTROCARDIOGRAM ON THE 14TH DAY IN THE HOSPITAL.

ration in 2.9, globulin 2.7. This is at the nost striking because the albuto in hin is low. The globulin is not particularly affected. With liver my rel lisease I would expect the globunin of in to be up and perhaps the ale died bumin not to be impaired.

, albu I cannot clearly interpret those

results. At long last, on the day of death, three blood cultures were reported as growing an unidentified strep. She, of course, had been under treatment with penicillin, 16 million units a day, and streptomycin, 1 gm twice a day, during this period, but certainly her disease was not alleviated.

The first electrocardiogram (April 16) was normal (Fig. 2). On April 22, S-T changes were observed which could be due to digitalis. On the 27th, some twelve days after her admission, the protocol suggests that the changes present were purely the result of digitalis, but on the 29th, two days before her death, the electrocardiogram was stated to be abnormal (Fig. 3), probably with posterolateral ischemia.

I was unhappy with the electrocardiographic reports in the protocol, because they hardly substantiate what I had in mind that this patient ought to have. So, after arrival here today, I looked at the tracings myself, and I am rather impressed with these tracings. The first tracing was made on April 22, and what strikes me as peculiar is that here we have a tendency to right axis deviation, with a fairly significant S wave in lead I, a significant S wave in V4 and a depression of the S2 junction in V6. This raises several questions. It may be of interest that peri-infarction block and diaphragmatic infarction can produce an S1, and can produce ischemic and other changes in V6.

One may wonder whether this

patient did have an acute myo ufficience cardial infarction due to an em lation al bolus after hospitalization, and in the se whether at least part of her clini ect (thr cal course in the hospital might alva), the have been related to that. I defere ma not believe that this happened of the p although the thought was enter proportion tained, in view of the electro expect t cardiograms. The S wave in lead liency. V1 is consistent with the fact that Let's this patient had right heart strain, how. I liver enlargement, and so forth; intil a fe but why should she have right DR. A heart strain so quickly after the s the che involvement of the aortic valve of admis

It so happens that I have see negative.

some cases of this sort before as point I speculated that perhaps there ere of was a hole in this heart some which is where, which had been acquired ion of t as a result of bacterial endocar can see, ditis, and therefore I refined mes obvior diagnosis to suggest that then he heart may have been involvement of the tr the sinus of Valsalva with per-thest. T foration into the right heart.

X-ray

Here is the x-ray of the chest There Certainly this patient, with this of the much shortness of breath and evilungs ar dence of heart disease, should patible show two things at the very least passive in this x-ray. One would be pul no calcin monary congestion and the sec that can ond would be enlargement of the otherwis left ventricle from the aortic in pleural

ence in nonary

t is strai

myo afficiency. Certainly, if my specem alation about such a possible hole and a the septum of the heart is corclinic ect (through the sinus of Valnigh alva), then I would suspect that I di here may be some prominence end of the pulmonary artery out of interproportion to what you would ctre expect the early aortic insuffileal siency.

that Let's see what this x-ray does train how. I had not seen it before orth, intil a few moments ago.

right DR. ALBERT J. MIELE: This r the s the chest film taken on the day alve of admission, and it was reported sen legative. But as Dr. Ethridge for has pointed out, there is evidence then here of cardiac enlargement, ome which is predominantly in the reuire ion of the left ventricle. As you ocar can see, the apex is down and it d mys obvious that the diameter of then he heart is greater than one-half nt of the transverse diameter of the per thest. There is also some promihence in the region of the pult. nonary artery segment, in that t is straightened.

thest. There is minimal engorgement in this of the central vessels in both devi lungs and this would be comhould patible with a minor degree of least passive congestion. There was the pull no calcification within the heart the secondary that can be seen. The lungs were of the otherwise clear, and there is no ic in pleural fluid. The lateral film

goes along with what you see in the posteroanterior film. The second film was made seven days after admission, and at this time the heart size is essentially the same.

Congestion

The straightening is slightly more prominent in the region of the pulmonary artery segment, and the congestion is a little more evident. The left costophrenic angle is blurred by a meniscus, indicating some free fluid in the pleural space. Though one can't actually see a retrocardiac density on this film, the lateral film does show an ill-defined density in the costophrenic sulcus posteriorly.

With the presence of passive congestion and the density appearing in the lung like this, involving the two pleural surfaces and a small pleural effusion, the first thought that comes to mind is that of pulmonary infarction. However, one has to include the possibility of pneumonia being superimposed, and these two entities can't be distinguished at this time.

The other signs that one would hope would be present for pulmonary infarct would be an elevated diaphragm, which tells you that the patient has pain and also some atelectasis in the lung, reflecting the splinting from the pain and the difficulty in breathing. So at this time we have the enlarged heart with passive congestion and a parenchymal density in the left base with a minute pleural effusion, probably a pulmonary infarct.

Dr. ETHRIDGE: This lesion in the left base in the sulcus might be infarction or pneumonia or, of course, it could have been both. A patient this ill, confined to bed, might develop a stasis pneumonia at the base. On the other hand, a patient ill and in bed could begin to develop a leg vein thrombosis from which a source of emboli might originate and might produce this picture in the x-ray. Also with my fancy diagnosis, I am a little concerned whether there might be a vegetation going into the right heart. and whether this might be the source of an embolus going into the left lung base.

Therefore, my impression would be the following: This patient, with perhaps an antecedent hepatic nutritional impairment, developed a renal infection and then later a bronchitis and perhaps the bronchitis was actually related to the inception of bacterial endocarditis. There ensued for a period of about four months prior to her admission, a subacute septic condition involving the lie. Per aortic valve.

Progressive failure

This began to exact its toll and mortem. finally produced a deformity of So pe the aortic valve and perhaps a live-eigh hole in the aortic valve. Thing die, and began to move fast after she cent live came into the hospital, and recogniz despite therapy, there was on ad cure the mission, and there continued to cure the be, evidence of rather severe and chanical progressive right heart failure, the hear which terminated in her death. I ing and therefore speculate and believe that this would not be the result of a myocarditis causing the rapid DR. V heart failure, which can occur in took at these circumstances by an em for this bolus to the coronary artery, no appear. indeed by the mechanical aspects sometime of aortic insufficiency, because In the 1 the period of heart failure was but I just much too short for this.

I would believe that there was penicilli a hole in the heart, between the parently left heart and the right heart fection through the sinus of Valsalva is not kn producing a major disturbance in received circulation. Though we do haw pills. I antibiotic agents which are very antibioti effective in handling and curing modified infections, the results in bacterial at that endocarditis are far from satisfactory. Statistics would indicate that about 50 percent of patients DR. I with bacterial endocarditis still autopsy

we in whom th and it

antibioti

the die. Perhaps more than that die f we include those patients on whom this diagnosis is not made, and it is found only at postant mortem.

y of So perhaps I would say that ps i live-eighths or about 62 percent ning die, and approximately 37 pershe cent live. It is also important to and recognize that though you may not do cure the infection, you may not do cure the disease, because the methanical injury that can occur to illure, the heart may be rather interestant. I ing and striking.

liew esult Antibiotic

rapid DR. VERNON E. MARTENS: It ur in took approximately two weeks em for this alpha Streptococcus to not appear. This is a little long; pects sometimes it will take ten days. aus. In the history it is not apparent was but I just wonder if she had some antibiotic before she received the war penicillin in the hospital. She apthe parently did, before the real ineart fection began. How long before alva is not known, but she did say she ce in received an injection and some have pills. I assume that they were very antibiotics, and they may have aring modified the bacteria responsible terial at that time.

satisicate Autopsy

ients

still

Dr. Henry W. Edmonds: At autopsy it was noted that there



Figs. 4 and 5. Streptococcal endocarditis of left coronary cusp and part of the adjoining right coronary cusp. The left cusp had been torn so that it could flop up (as in Fig. 4) to lie in front of the left coronary orifice, or down (as in Fig. 5) into the heart.



was some clubbing of the fingertips and a possible splinter hemorrhage was noted underneath one of the fingernails, verifying what was described during life. The right pleural cavity contained 1000 ml of serous fluid, the left 800 ml, and another 100 ml were found in the pericardium. There was no appreciable ascitic fluid; these effusions are, of course, consistent with passive congestion.

The heart weighed 340 gm, and was but slightly enlarged; we think of 300 gm as a normal upper limit for a woman. The valves had essentially normal circumferences; that of the aortic valve was 7 cm. This valve had three cusps. The posterior or noncoronary cusp was thin and well formed; the right and left coronary cusps were partly fused at the commissure.

Part of the coronary cusps were of normal texture and form, but the remainder was covered by a vegetative excrescence. In addition, the left coronary cusp had been torn so that it could flop up or down (Figs. 4, 5). The interventricular septum was not perforated. The other valves of the heart did not show any lesions. Microscopically the vegetation consisted of fibrin and globular colonies of tiny cocci consistent with Streptococci.

The myocardium throughout the left ventricle was somewhat softened, and had a rather striated, yellowish, mottled, gross appearance. Microscopically there was a number of small poorly defined areas in which th muscle fibers appeared well pit served, yet in between them ther were many polymorphonucles leukocytes. The heart muscle cel included frequent rodlike, irrita tive forms of nuclei (Anitschkor cells). These lesions are a form of focal, acute myocarditis, and not an infarctive change of the muscle. Healing of such a lesion, however, might result in multiple small focal scars throughout the mvocardium.

Enlarged liver

The liver weighed 1960 gr (1300 gm is normal weight for a woman). It was enlarged and on cross-section showed accentration of markings, in the "numeg" pattern which we associate with chronic passive congestion Microscopically, this means dilutation of sinusoids in the central areas of the lobules, with corresponding congestion of sinusoids

The spleen was enlarged he area weight), was firm and dark, consistent with passive congestion, and in addition presented a sharply defined orange-yellou area which we interpret as a rather recent infarct. Microscopically, we find normal splenic

zone of filtrate leukoo

togeth half weigh ture tion v

Old in

Th

gm ea normal had a lower edge stage tion, lympl There urina time the p and e

In by a area arachtion meni contacytes noid.

parenchyma at the border of the zone of necrotic tissue, being infiltrated by polymorphonuclear leukocytes.

The lungs weighed 1860 gm together (between one and one-half and two times normal weight) and presented the picture of chronic passive congestion without infarcts, thrombi or emboli.

Old infarct

ically

smal

ch th

1 pre

ther

uclea

e cel

irrita

hkov

form

, and

of the

esion.

ultiple

at the

O gn

nt for

d and

centi

"nu-

ocian

estion

dil

entri

COTT

soid

ed to

twice

and

e con

sented

vellow

as a

Aicro-

plenio

ysician

The two kidneys weighed 210 gm each (somewhat in excess of normal) and one of the kidneys had a small, old, infarct in the lower pole. A section along the edge of this infarct shows a late stage of healing with scar formation, and residual infiltration of lymphocytes along the periphery. There had also been a lower urinary tract infection at some time in the past, as evidenced by the presence of ureteritis cystica and cystitis cystica. I think this was an older, inactive lesion.

In the brain we were impressed by a poorly defined orange-brown area of discoloration in the pia arachnoid, and on histologic section we found a low grade leptomeningitis, with the pigmentcontaining macrophages, lymphocytes, etc., in the pia arachnoid. This is a form of low grade leptomeningitis, sometimes assocciated with bacterial endocarditis, believed to be on a hematogenous basis.

Summary

This was a case of subacute bacterial endocarditis involving the aortic valve with rupture of one of the cusps, chronic passive congestion of the lungs, liver, spleen and kidneys, embolic phenomena in the spleen and kidney and low grade leptomeningitis.

DR. ETHRIDGE: My face is not too red - I would assume that from a clinical point of view the ruptured cusp plus the myocarditis explained the rather rapid termination in this case. course, the septic state of the patient because of the continued state of infarction and embolism and so forth, was significant as well. It may well be that this vegetation on the aortic valve may have been large enough on admission to preclude a rather wide open aortic insufficiency type of thing. But as therapy was continued and time passed, the vegetation perhaps moved or became less in size, allowing the aortic insufficiency to increase under clinical observation. This was a fascinating case. One thing is true in dealing with bacterial endocarditis - one must remember that anything can happen.



one of a series on leading

a volu cated Washi exister 778-b ical he

Three of the oldest hospitals in the Nation's Capital were merged in the founding of this new center. With limited medical school affiliations, it provides training for 45 interns and 86 residents in approved programs.

o Hospital Center

Washington Hospital Center is a voluntary, nonprofit hospital located in the northwest section of Washington, D.C. Though in existence only three years, this 778-bed facility has a rich medical heritage.

leadi

cente

It was created through the merger of three of the oldest hospitals in the Nation's Capital —The Central dispensary and Emergency Hospital (founded in 1871), Garfield Memorial Hospital (1882), and the Episcopal Eye, Ear and Throat Hospital (1897).

Constructed at a cost of \$24 million, the Center admitted its first patient on March 10, 1958. Twenty months later, in November 1959, the 100,000th patient was treated.

Located on a landscaped 47acre campus, the Hospital Center is removed from midtown noise and congestion, yet is easily accessible by public and private transportation. Its parking facilities can accommodate more than 1100 cars. A school of nursing adjoins the hospital and is equipped to house 288 students.

As one of the newest installations of its kind on the Eastern Seaboard, the Hospital Center was designed to provide efficient placement of patients and facilities. Patients' rooms have electrically operated beds, built-in oxygen and suction outlets and an intercommunication system with the nursing station. There is



a spreading pattern of therapeutic success

A rewarding approach to the emotional and somatic manifestations of anxiety, agitation and tension, Librium therapy is now being utilized in many different areas of general practice. Approximately 3.5 million Librium-treated cases, as well as more than 70 published reports, offer testimony to this spreading pattern of therapeutic success. They corroborate observations, gained over a span of more than three years, that Librium is pharmacologically and clinically in a class by itself.

Librium has been found of value in alleviating anxiety and tension associated with

emotional disturbances

- · Mild neurosa
- + Agitation + Neurasthenia
- Psychasthenia
- Emotional instability
- · Post-traumatic agitation
- · Pre- and postoperative apprehension
- Irritability Habit spasm or tic
- Hypochondria
- Hyperventilation syndrome

personality disorders

- · Alcoholism · Drug addiction
- Psychopathic traits
- Behavior problems in children

cardiovascular conditions

- · Hypertension
- Angina + Coronary thrombosis
- Myocardial infarction Tachycardia

gastrointestinal disorders

- · Utcer syndror
 - Functional G1 distress
- · Gastritis · Colitis
- Pylorospasm G.I. spasn
- · Bowel problems
- Reactive anorexia Aerophagia

gynecologic disorders

- · Premenstrual tension
- Dysmenorrhea
- · Menopause

dermatologic disorders

- · Acne · Dermatitis
- · Neurodermatitis · Urticaria
- · Erzema · Seborrhea · Papular itch
 - Dyshidrosis Pruritus Psoriasis

other medical disorders

- + Arthralgias + Arthritis
- . Patientilities Alleren
- · Asthma · Imnotonce
- lension headache Insomnia
- · Neuralgia · Migraine

psychiatric disorders

- Olisessive-compulsive reactions
 - Phobic reactions + Hypomania
- Somatization reaction



Consult literature and dosage information, available on request, before prescribing.

ROCHE

APPENDING

a pneumatic tube system throughout the hospital for rapid distribution of key data and pocket radio receivers are used in conjunction with the paging system.

Other facilities, from the clinical laboratories to the 16-room surgical suite, are equally modern.

ern.

The emergency unit consists of an interns' work room, two observation rooms with a total of 19 beds, four treatment rooms, nurses' station and waiting room. Here, about 3000 patients are treated each month.

The Center has limited affiliation with George Washington University Medical School and Georgetown University Medical School, and 47 percent of the members of the active and consulting staffs are on the faculties of local medical schools. Of the entire active staff, 66 percent are Board-certified.

The active staff numbers 400 physicians in private practice who are responsible for teaching the resident and intern staffs and supervising the professional care of patients. The director of medical education serves on a full-time basis.

Guest speakers and participants in teaching conferences come from local medical schools and the staffs of such institutions as the National Institutes of Health, Armed Forces Institute of Pathology, Walter Reed Army Research Institute, Walter Reed General Hospital and the National Naval Medical Center. From time to time, distinguished foreign physicians, visiting in Washington, are invited to the Center.

The Center provides training for 45 interns and 86 residents in ten approved programs: anesthesiology, internal medicine, obstetrics and gynecology, ophthalmology, orthopedics, otolaryngology, pathology, radiology, surgery and urology.

There are 36 rotating, six straight surgical and three dental internships. Appointments are made for one year starting July 1.

It is the policy to give preference in residency programs to Center interns. Other credentials are evaluated in accordance with

Completed three years ago, he inter's bu



Resident Physician

appro and a yearly ment

Surg

gery. first y the mont ties a surge

Th

from reside tical i five take traini dency otolar subsp

Du ident edge

May

approved residency requirements, and appointments are subject to yearly renewal by mutual agreement.

Surgery

of

te

IV

ed

a-

Τ.

ed

in

ne

ng

in

S-

et-

1-

y,

nd

ix

tal

re

1.

er-

to

als

ith

ago, h

ian

There are 17 residents in surgery. Assignments during the first year include three months in the emergency room, three months in the surgical subspecialties and six months in general surgery.

Three candidates are selected from the group of eight first year residents to continue in the vertical four-year system. The other five first-year residents usually take one year of general surgical training prior to pursuing a residency in orthopedics, urology, otolaryngology or other surgical subspecialties.

During the second year the resident acquires a working knowledge of gross and microscopic

pathology and anatomy (four months). The remaining eight months he works an equal time in general surgery and in the surgical subspecialties. Surgical assignments include clinical ward and operating room responsibilities and work in the surgical outpatient department.

The third year resident is affiliated at Children's Hospital for four months of pediatric surgery and is responsible for private and staff patients admitted to his service. He then returns to WHC and is assigned to the gynecological service for four months and general surgery for the remaining four months.

The chief resident (fourth year) has a wealth of clinical material from which to select his own patients. For eight months he controls his own service and ten beds for patients of his choice. Under the supervision of the

inter's buildings are located on 47 acres in northwest section of the District.



Washington Hospital Center

Total admissions (15% staff)
Total outpatient visits
Emergency visits (Emergency Room) 34,650
Admissions by service
Medicine 6,998
Surgery 8,444
Orthopedic surgery
Dental and oral surgery 100
Otorhinolaryngology
Ophthalmology
Obstetrics 4,092
Gynecology
Hospital procedures
Operations
Anesthesiology (surgical and
obstetrical) 18,829
Radiological examinations 47,892
Isotope studies and therapy 791
Radium and roentgen therapy 9,393
Clinical laboratory tests352,010
Surgical specimens 11,411
Autopsies (56.8% of total deaths). 507
Electrocardiograms 6,000
Electroencephalograms 876

sibilition car duct and geo mo pri

Ma



attending surgeon he is responsible for the workup, preparation, surgery and postoperative care of all staff patients. He conducts his own teaching rounds and those of the attending surgeons. The remaining four months he is responsible for the private surgery of the hospital.

The schedule of surgical

rounds and conferences includes daily teaching rounds, and weekly surgical conferences, surgical pathology conferences and grand rounds. Death and complication conferences are held monthly.

During the past fiscal year the general surgical service cared for more than 16,000 patients, representing all types of surgery.

cian

Medicine

There are 12 medical residents, with four in each year of training. They assist in the care of a large inpatient medical service (200 patients daily). Twenty-two staff beds are allocated and regular teaching rounds are conducted daily on the staff and private services.

The outpatient department averages more than 20,000 patients annually. Each resident in medicine has an outpatient assignment which he maintains throughout his residency so that he can follow his patients for a period of three years. This is in addition to subspecialty teaching outpatient clinics which are conducted by attendings.

The emergency room and emergency ward provide approximately 3,000 visits a month. About 50 percent are medical, providing a broad experience in acute medicine. Residents are given full time assignments of several months in this facility in both their first and third year of training. The attending staff in the outpatient department (clinics) and emergency service provide supervision and daily teaching rounds.

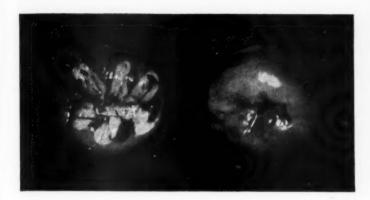
A full program of teaching conferences and seminars is conducted throughout the year with periodic special lectures by guest speakers. Medical grand rounds are conducted twice a month; there is a monthly clinical pathological conference and a modified teaching morbidity and mortality conference.

Weekly teaching conferences are held with the departments of pathology and radiology and special teaching conferences are conducted in the subspecialties at regular intervals.

On alternate weeks medicalsurgical chest conferences and medical - surgical gastrointestinal conferences are held. A weekly formal teaching clinic is conducted by the chairman of the department of medicine. The residents and members of the attending staff participate in the weekly tumor board proceedings. The resident staff conducts an active journal club which meets weekly.

Ob-Gyn

Although independent, the obstetrics and gynecology departments are combined under one administrative chairman for administrative and teaching purposes. During a four year period, the eight residents receive 36 months of training devoted entirely to obstetrics and gynecology and 12 months of training in sur-



For your OB-GYN patients: fight infection, facilitate healing

ds h; hdi-

of enat

al-

nd

al

n-

he he

he

he

S.

an

ets

b-

rt-

ne

d-

11-

36

n-

gy

11-

an

Administered before and after cervicovaginal surgery, irradiation, delivery, and office procedures such as cauterization, Furacin helps to provide a shorter, more comfortable convalescence. Infection is promptly controlled; discharge, irritation and malodor reduced; healing hastened. Furacin is highly active in the presence of exudates, yet is nontoxic to regenerating tissue, does not induce significant bacterial resistance nor encourage monilial overgrowth.

FURACIN



Vaginal Suppositories

FURACIN 0.3% in a water-miscible base which melts at body temperature. Box of 12, each 2 Gm. suppository hermetically sealed in yellow foil.

Cream

FURACIN 0.2% in a fine cream base, water-miscible and self-emulsifying in body fluids. Tubes of 3 oz., with plastic plunger-type vaginal applicator.

NITROFURANS-a unique class of antimicrobials EATON LABORATORIES, NORWICH, NEW YORK

A Day in the Teaching Program of Washington Hospital Center

ROUNDS AND CONFERENCES

8:30 a.m.	Attending Rounds, Medical Service
9:30 a.m.	Attending Rounds, Obstetrical Service
11.00 a.m.	Attending Rounds, Newborn Service
12:00 noon	Grand Rounds, Medicine
1:00 p.m.	CPC, Medicine
2:00 p.m.	Mortality Conference, Medicine
3:00 p.m.	Grand Rounds, Otolaryngology
4:00 p.m.	Surgical Gynecological Conference
5:15 p.m.	Attending Rounds, General Surgery

SPECIAL LECTURES

2:00 p.m.	Electrocardi-
	ography
8:30 p.m.	Ophthalmology Pathology

TEACHING CLINICS

9:30 a.m.	Cardiology Clinic
12:00 noon	Allergy Clinic, Medicine
1:30 p.m.	Pulmonary Clinic

gery, pathology and female urology. The two fourth-year residents are appointed as senior residents and each spends six months in complete charge of his department in gynecology and six months in obstetrics.

In addition to the clinical work provided, a definite schedule of formal lectures in the basic sciences is given. Regular rounds are held each day with the attending obstetrician or gynecologist in addition to formal conferences in each department once or twice each week. Weekly conferences are held for the entire combined active attending staffs in which interns and residents participate.

Anesthesiology

Training in anesthesiology is approved for 15 residents in a three-year program. The ten staff members involved in this program are all either Diplomates of the American Board of Anesthesiology or are Board eligible.

The departmental basic science program of four hours weekly is augmented by 30 weekly basic science lectures by outstanding guest lectures. Resident seminars are held monthly with senior attending anesthesiologists. Anesthetic records, clinical problems, morbidity and mortality reports, resident research programs, jour-



■ revives appetite ■ increases weight

Newman1 has reported an experience which illustrates the gratifying nutritional progress physicians^{2,3} often find when they prescribe Nilevar. He states:

"One of the most distressing jobs on the poliomyelitis ward is the dietitian's because most of the food comes back uneaten.... After the administration of Nilevar, the dietary department and the nurses had to have a conference about who was going to get the second breakfasts and the midnight meals. . . . there is no doubt - there is a change in appetite."

Nilevar improves nutrition not only by increasing appetite but also by giving specific anabolic impetus to the body's utilization of food. All evidence indicates that the weight thus gained is deposited as muscle tissue so that typically patients both gain weight and retain weight with Nilevar.

The usual adult dosage is 30 mg. daily, adjusted to the anabolic needs and the response of individual patients. For children the recommended daily dosage is 0.5 mg. per kilogram or 0.25 mg. per pound of body weight.

Nilevar, brand of norethandrolone, is supplied as uncoated, unscored white tablets of 10 mg. each; as drops supplying 0.25 mg. per drop; and, for intramuscular injection, ampuls of 25 mg. each.

G. D. SEARLE & CO.

CHICAGO 80, ILLINOIS

Research in the Service of Medicine

1. Newman, E. V.: Proceedings of a Conference on the Clinical Use of Anabolic Agents: Discussion, Chicago, Searle Research Laboratories, 1956, p. 44.

2. Brown, S. S.; Libo, H. W., and Nussboum, A. H.: Norethandrolone in the Successful Management of Anarcsia and "Weight Lag" in Children, Scientific Exhibit presented of the Annual Meeting of the American Academy of Padiatrics, Chicago, Oct. 20-23, 1958.

3. Wotson, R. N.; Bradley, M. H.; Collahan, R.; Peters, B. J., and Kory, R. C.: A Six-Month Evaluation of an Anabolic Drug, Norethandrolone, in Underweight Persons: 1, Weight Gein, Am. J. Med. 26:238 [Feb.] 1959.

nal reviews, examinations and complaints are discussed.

The department has its own analytical and radioactive isotope laboratory and residents are encouraged to initiate research projects or join projects in progress. In addition, the department has its own research foundation to underwrite the cost of research projects in anesthesia and related fields, and supplement the income of deserving residents who demonstrate unusual aptitude and are willing to work beyond the usual duty hours.

Approximately 20 percent of patient admissions for surgery and anesthesia are staff patients. In the past fiscal year, 18,829 anesthetics were administered.

Otolaryngology

The program in otolaryngology is as follows:

First year: assignment to the outpatient clinic and inpatient otolaryngology wings under supervision of senior residents and attending staff with special attention to diagnostic and therapeutic procedures.

Second year: three months at the Armed Forces Institute of Pathology; three months at the Audiology and Speech Center of the Walter Reed General Hospital; six months at Children's Hospital for training and practical experience in an active outpatient and inpatient service in the diagnosis and therapy of pediatric otolaryngology.

Third year: in the inpatient wings, operating room and outpatient clinic of the Hospital Center. Each of the two residents in this third year serve as chief resident for a six month period. They have assigned staff beds and the opportunity of performing all types of surgery pertaining to the specialty under the supervision of the attending staff.

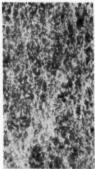
Ophthalmology

All aspects of ophthalmology are covered in the three-year program which includes training in pediatric ophthalmology at Children's Hospital and ophthalmalic pathology at the Armed Forces Institute of Pathology. In the last year the resident has his own clinic surgical cases. Monthly outpatient volume in the eye clinic of approximately 1,700 patients insures a generous number of surgical and nonsurgical patients. There is a fully equipped and actively functioning ophthalmic pathology laboratory.

A formal lecture program, featuring outstanding ophthalmologists from local and out of town areas, is presented each Saturday tra

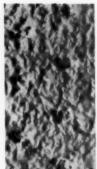
10

Ea



NEW "SCOTCH" BRAND SURGICAL TAPE

Macrophoto of "SCOTCH"
Surgical Tape shows exclusive
proporus structure of the
physiologically inert adhesive
and non-woven backing. Air
passes through the tape freely
perspiration and exudates
evaporate rapidly.



PERFORATED ADHESIVE TAPE

In contrast, conventional, nonporous tape has a thick layer of adhesive which forms an occlusive barrier that plugs the widely spaced perforations, entraps hairs and contains potentially irritating natural rubbers and resin

TAKE A CLOSE LOOK AT A TOTALLY NEW CONCEPT IN SURGICAL ADHESIVE TAPE

Over three years in development, "SCOTCH" Brand Surgical Tape dramatically answers the traditional problems of ordinary adhesive tape, as established by clinical test in more than 1000 cases. (Golden, T., A Non-Irritating, Multipurpose Surgical Adhesive Tape, Am. J. Surg. 100: 789, 1960.) Non-occlusive: prevents usual maceration. Cool, lightweight, comfortable. Easy to tear, handle, apply. Physiologically inert: Virtually eliminates chemical irritation, even in markedly tape-sensitive patients. Easily removed: Thin, non-creeping copolymer adhesive removes without depilation, yet outholds all previous tapes. Sticks even in baths; requires fewer changes. Available now: order through your surgical supply dealer or pharmacy in usual widths, V_2 " to 3", 10-yard rolls.

Reg. U. S. Pat. Off.

SCOTCH SURGICAL TAPE MICROPOROUS

MINNESOTA MINING AND MANUFACTURING COMPANY

... WHERE RESEARCH IS THE KEY TO TOMORROW

"SCOTCH" is a registered trademark of 3M Co.

(1) 3M Co., 1961



Autopsy review, part of the pathology training program, is held weekly. The Center offers eight residencies in the specialty.

morning for nine months of the year. In addition to the formal instruction there are daily ward rounds, weekly teaching rounds, journal club activities, monthly clinical-pathological conferences and constant staff supervision during the daily clinics.

Orthopedics

The department of orthopedics offers a three-year program for training in adult and children's orthopedics. The Center maintains an affiliation with Children's Hospital for rotation of residents.

A basic science course is offered and a special course in bone pathology is given annually. The resident staff is provided ample opportunity to review both

gross and microscopic material. In addition, a series of lectures on bone pathology is given at the Armed Forces Institute of Pathology. Daily staff rounds, weekly lectures and radiology conferences are conducted in addition to monthly journal club meetings and grand rounds. Research is encouraged and residents can participate in any of the programs in progress.

The outpatient department offers opportunity to see a variety of orthopedic problems. Residents conduct regular orthopedic outpatient clinics and are responsible for evaluation and treatment of acute traumatic injuries in the emergency room under the supervision of the attending staff. They

DI

of

CO

ot

a pair of cardiac patients:



both are free of pain-but only one is on

DILAUDID

(Dihydromorphinone HCI)

swift, sure analgesia normally.unmarred by nausea and vomiting

DILAUDID provides unexcelled analgesia in acute cardiovascular conditions. Onset of relief from pain is almost immediate. The high therapeutic ratio of DILAUDID is commonly reflected by lack of nausea and vomiting-and marked freedom from other side-effects such as dizziness and somnolence.

> by mouth by needle **by** rectum

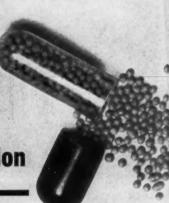
2 mg., 3 mg., and 4 mg.

May be habit forming—usual precautions should be observed as with other opiate analgesics.



KNOLL PHARMACEUTICAL COMPANY · ORANGE, NEW JERREY

for the first time adequate iron in convenient sustained-release form for more efficient assimilation

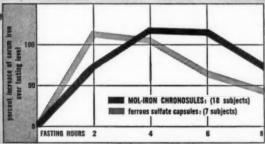


Mol-Iron Chronosules

for improved treatment of iron-deficiency anemia now controlled release of more adequate amounts of iron in a form compatible with the body's ability to utilize iron

- Each Mol-Iron® Chronosule® contains 390 mg. of ferrous sulfate and 6 mg. of molybdenum oxide—sufficient iron to achieve effective therapeutic response.
- Gradual dosage release means greater patient tolerance—with minimal likelihood of gastrointestinal disorders.
- Marked increases in hemoglobin and hematocrit levels through sustained liberation of more absorbable Mol-Iron throughout gastroileal transit.
- Thus, all the advantages of Mol-Iron, the specially processed, co-precipitated complex of ferrous and molybdenum compounds, now in the form most conducive to efficient assimilation.

Comparative patterns of gastrointestinal absorption of iron following standardized test doses of Mol-Iron Chronosules and of ferrous sulfate capsules (normal fasting adults)



The curve for ferrous sulfate reflects a sharply increased absorption of iron during the first two-hour period, and a progressive waning of absorption during each of the succeeding test intervals. In contrast, the curve for Mol-Iron Chronosules mirrors a sustained and efficient rate of iron absorption over a full six-hour span following oral intake.

Desage: Adults - one Mol-Iron Chronosule daily. In severe anemia, one Chronosule twice daily. Children - one Mol-Iron Chronosule daily. Supplied: In bottles of 30 Chronosules.

White

WHITE LABORATORIES, INC. Kenilworth, New Jersey

are responsible for the work-up and pre- and post-operative care of patients on the assigned patient wings and perform the operations on staff patients (300 annually) under supervision of attending orthopedic sugeon.

Pathology

A residency in pathology is designed to train for the practice of pathology in a hospital department or in a private laboratory. Emphasis is placed on the scientific aspects of training but residents are also made aware of administrative problems.

The program is designed for eight residencies and two fellows in cancer research. Residents are rotated between clinical pathology and pathologic anatomy on the basis of two years in each division. However, a four year program can be offered in either clinical pathology or anatomical pathology.

The department operates laboratories totaling more than 26,-000 square feet and equipped with the latest type of scientific equipment. Residents in clinical pathology have the added advantage of their own private laboratory. In the past fiscal year there were more than 350,000 clinical laboratory procedures, 11,500 surgical specimens examined and more than 500 autopsies performed.

Weekly conferences are held on laboratory medicine, surgical pathology and autopsy pathology. In addition, a monthly clinicopathologic conference is held in collaboration with the department of medicine and a tumor board conference is held in conjunction with the tumor clinic of the Hospital Center.

Radiology

The resident staff consists of two first-year residents, two second-year residents, and two third-year residents.

Although most of the training is of the preceptorship type, weekly didactic lectures are given by the radiology staff from September through June.

The first year of residency is devoted to Roentgenological technique, radiation physics and orientation into the general scope of Roentgen diagnosis under the direction and supervision of an assigned member of the department. Seven months of the second vear are devoted to diagnosis. The second year residents are responsible for fluoroscopy and film reporting. During the second year attendance is required at all of the x-ray interdepartmental conferences. The resident serves

a course of **Anabolic Therapy**

stimulates appetite, strength, vitality

builds vital protein tissues -

Muscle¹ increased size and strength

combats demineralization. rebuilds stroma

improves mood and outlook. physiologically

urabo

(nandrolone phenpropionate injection, Organon)

the safest and most potent sustained anabolic therapy

1. virtually free of virilizing effects
2. sustained over 7-14 days

3. under your direct control

4. no adverse effect on liver function

to improve mood and outlook; restore appetite, strength and vitality; relieve pain; stimulate gain in solid muscular weight; hasten recovery. Your patient feels better because he is better.

Indications: anorexia, chronic fatigue and post-viral debility, osteoporosis, mammary cancer, pre- and post-surgery, severe burns and trauma, and other catabolic conditions. *Dosage*: Adults: 50 mg., i.m.; then 25 to 50 mg., i.m., weekly for twelve weeks. Children: 2-13 years-25 mg., i.m., every 2 to 4 weeks. Infants: half children's dose. Supplied: DURABOLIN (25 mg. nandrolone phenpropionate/cc.) in 5-cc. vials and 1-cc. ampuls (box of 3). New Durabolin-50 (50 mg. nandrolone phenpropionate/cc.) in 2-cc. vials.

Osol, A. and Farrar, G. E., Jr.: The Dispensatory of the U.S.A., ed. 25, J. B. Lippincott, Phila., 1955, p. 1392.
 Best, C. H. and Taylor, N. B.: The Physiologic Basis of Medical Practice, ed. 7, The Williams and Wilkins Co., Balt., 1961, p. 1104.

Organor

Organon Inc., W. Orange, N. J.



House officers and attendings participate in CPC.
Conferences are held monthly at the Center.

as a consultant with members of the house staff in regard to staff patients. The resident undertakes supervision of all routine diagnostic procedures such as chest, extremities, pyelograms, cholangiograms, cholecystograms, etc. Five months are spent on therapeutic radiology.

In the third year, seven months are devoted to diagnosis and five months to therapy. Residents are completely in charge of all staff cases in both diagnosis and therapy, consulting at will with the radiologists.

Urology

A three-year urological residency has recently been established at the hospital, and is designed to lead to certification by the American Board of Urology. It offers training in pathology, radiology, pediatric urology, cystoscopic procedures, and all types of major urological surgery.

The library is under the super-

vision of an experienced medical librarian and contains an extensive collection of modern books and more than 160 current journals. In addition, there is the combined collection of journals from the three parent hospitals.

Interns receive a monthly stipend of \$200 plus full maintenance. Quarters are air-conditioned and there are kitchen and pantry facilities. In addition to two weeks' paid vacation, hospitalization and medical care are provided.

Monthly stipends for residents follow this scale: first year, \$215; second. \$230: third. \$245: fourth, \$260. Full maintenance and other benefits available to interns also apply to residents. Married residents may elect to have an additional \$100 per month in lieu of quarters and meals at the hospital. The administration assists in locating housing and employment for residents' wives.

Prov

norr

requ

for

tio

avo

cess

of i



BAKER'S MODIFIED MILK PROVIDES OPTIMUM PROTEIN NUTRITION

"There is abundant clinical evidence ... that formulafed infants receiving high protein allowances compare favorably to thriving breast-fed infants."1 Authorities.2 whose experience with the hunger of infants fed even 3.5 grams of protein per kilogram, have opposed intakes of cows' milk which would give less protein.

Baker's Modified Milk supplies a protein level of 3.7 grams per kilogram of body weight per day to meet normal needs and to provide a dietary reserve for increased protein demands caused by fever, diarrhea and infections. An adequate water reserve is also provided for renal function and proper water balance by the 20 Cal/oz, dilution,3

posed of multiple sugars, the R.D.A.5 of vitamins, and 7.5 mg. of iron per quart of formula.

Because an infant's health depends upon total adequacy of his diet,4 Baker's Modified Milk supplies an optimum protein level, 6% of the calories as essential linoleic acid, and contains 7% carbohydrate com-

 Hill, L. F.: J. Pediatrics 54: 545 (1959)
 Gordon, H. H., and Ganson, A. F.:
 J. Pediatrics 54: 503 (1959)
 A.A.P. Committee on Nutrition, Pediatrics 19: 339 (1957) 4. Woodruff, Calvin W.: J. A. M. A. 175: 114 (1961) 5. Recommended Dietary Allowances, NAS-NRC Publication 589 (1958) 6. U.S.P.H.S. Milk Code, Federal Security Agency Publ. 220 (1953)

Baker's MODIFIED MILK

Made only from Grade A milks-scientifically formulated to duplicate Powder/Liquid the nutritional results of human milk.

THE BAKER LABORATORIES, INC., Cleveland 15, Ohio



e

1

)

OPTIMUM NUTRITION Providing all the normal dietary requirements plus a reserve for stress situations while avoiding the hazards of excessive amounts of individual nutrients.



Teaching Hospitals and the "Doctor Shortage"

It is frequently stated that the prestige of American medicine has never been higher. Our medical schools, graduate medical education and specialty training are rated as superior throughout the world. The volume and quality of basic and applied medical research in this country exceeds that found in other nations. A paradox exists in that, in spite of these accomplishments and world prestige, our highly educated, prosperous, energetic nation is not, according to some, supplying sufficient well-trained physicians to provide for our rapidly growing population.

The annual output of medical graduates from our medical schools has increased over the past ten years but the increase has been small compared to the increases in total population and the apparent need for house staff by a rapidly expanding hospital program. The word has spread throughout the world that there is a marked shortage of physicians in the United States. Is this really true? Are we properly utilizing the physicians we have?

During the period of population explosion and hospital growth there has been a steady increase in the number of foreign medical school graduates coming to our country for graduate training and practice. Today, nearly one thousand



T. W. Mattingly, Director of Medical Education, Senior Attending in Medicine, Washington Hospital Center

become licensed physicians each year and either form a part of our annual increment of practicing physicians or join academic faculties or research staffs of medical institutions. Several thousand additional foreign graduates come each year for temporary residence for graduate training under the Exchange Visitors Program.

Concurrently with this attainment of world prestige in medicine and attraction of foreign graduates for

training and practice, we are witnessing another paradox: the profession of medicine is losing its prestige and attraction for the American youth in his selection of a profession.

There is both a quantitative decrease in total applicants as well as a reduction in the quality of applicants seeking admission to medical schools.

Perhaps this is a true reflection of the status of medicine and our prestige is not as high as we think—and there are other reasons why foreign graduates are coming to the U.S.

Perhaps another question may be asked: Is the shortage of doctors based on house officer requirements a real one? Some authorities definitely agree that a shortage as evaluated on such as basis is artificial. They indicate that it is a temporary situation created by a sudden increase in the total hospital beds made possible under the accelerated hospital construction programs stimulated and facilitated by federal and community support through the Hill-Burton Hospital Construction Act.

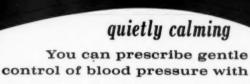
Hundreds of small, fifty to two-hundred bed hospitals suddenly demanded house officers, regardless of their ability to provide adequate graduate training. Existing hospitals of all types have increased their house staff quotas. Evidence of preponderant service demands and employment of foreign graduates in hospitals has resulted in cries of "cheap labor" in news periodicals.

The real question in the evaluation of the doctor shortage is, are interns and residents necessary and justified in every hospital and how much should this requirement be used in the determination of a national shortage of physicians? If so, we are dreadfully short! The recent report of the American Medical Association shows that of our nation's total of 1,600,000 hospital beds, only fifty percent are in hospitals having accredited house staff programs. Graduates of foreign medical schools make up about twenty-five percent of the house staff in these hospitals. Thus a shortage of American graduates exists in filling the one-half of our hospitals which at the moment are considered to have sufficient teaching aspects to justify an intern-resident program.

Our accrediting bodies are probably very generous in approving this fifty percent of existing hospital beds for training. If one is to take into consideration the total service requirements of all existing hospitals, I agree that the shortage is an artificial one and that we are not being realistic in approaching the problem. This country is not suffering from a great shortage of physicians in practice outside of hospitals and it appears it is essentially the service demands and abuses in hospital admissions that constitutes the chief

problem.

More realistic surveys such as that made in the report of the Surgeon General's Group on Medical Education indicate that based on our present population explosion and the increase to be expected for the next ten years, there is and will be a shortage in both physicians and in medical facilities in our country for undergraduate training of physicians. This group recommended both expansion of existing facilities and construction of new medical schools. These much needed national surveys have been an eye-opener and a stimulus not only to plan for expansion of existing schools and construction of new ones but we hope, a stimulus to a more realistic financial support to medical schools for education as well as



BUTISERPINE

Butiserpine contains just enough reserpine (0.1 mg. per tablet) to reduce tension without initiating side effects; 15 mg. of BUTISOL sodium® butabarbital sodium, to promote calmness without lethargy.

Butiserpine Tablets, Elixir, Prestabs® Butiserpine R-A (Repeat Action Tablets)

McNEIL

McNEIL LABORATORIES, INC. FORT WASHINGTON, PA. for research. We cannot do research without an adequate number of qualified graduate physicians to do the research. The successful completion of such a program, however, will be only a half measure in providing adequate provisions for the training of an adequate number of physicians for clinical practice. The need for good teaching facilities for graduate training at the intern-resident level must be surveyed and met as well.

I believe that we must look at the graduate training of a recent graduate as being equal to, or more important than his undergraduate training. There is no shortage of hospital beds for this training. What is needed and will be needed in addition to expanded medical school facilities with their university hospitals are good nonuniversity teaching hospitals and centers with teaching interest and experience, clinical research facilities and staffs, and supervised, coordinated programs. We will need hospitals and centers which will justify admission of a graduate for graduate training rather than places where he can work for a year before he can obtain a license to practice.

In recent years there have been many discussions at many national conferences and by many groups as to the definition of a "teaching hospital." Some answer by saying all hospitals teach, but the real question is, "What and how do they teach?" Such questions testify to the necessity for better evaluation, organization, direction and requirements of teaching programs. It has been agreed by many interested in this problem that what is needed is a Flexner-type evaluation of hospitals as to their quality of teaching, similar to that applied to medical schools in the United States in the first decade of this century. Apparently there is no one individual or group with the ambition and courage to undertake it or to demand it! This must be done before remedies can be provided. Few people in postgraduate medical education will deny it. I certainly cannot.

al

C

D

d

Can we afford the luxury of having physicians to perform all the service functions in all or even half of the hospitals in this country? The nursing profession has learned that it could not afford to continue to expend graduate nurses for maid services in hospitals. Today many of the previously performed and once considered essential duties of the general duty nurse are adequately performed by practical nurses, nurses aids, etc. There is a similar need for paramedical personnel for the performance of many of the service functions presently delegated to interns and residents. What we need are facilities and programs for the training of medical and surgical technicians for use in hospitals. We did it very effectively on a large scale for our military hospitals during the past war.

The use of graduates of medicine as ward secretaries to write histories in longhand that are never read or discussed by a busy attending physician, or their employment as technicians on the wards and in operating rooms is a luxury that medicine cannot afford. The simple procedure of providing good dictating equipment for use by the attending physician and a few high school graduates as ward clerks for typing would be a simple solution for history and physicals and chart requirements in many hospitals where the records will not be used for a real teaching program or on private floors not used for teaching.

I believe that if a real definition is given to a teaching hospital and if approval for admission for graduate training is given only to hospitals meeting this definition and requirement, that there would be a shortage of institutions for graduate training rather than a shortage of house officers for hospitals. We would have spaces for only a small number of carefully selected foreign graduates in our programs. We should insure this small group of a real educational experience which would permit them to return to their country as a proud product of American medicine and culture rather than returning with a "hate America" feeling resulting from service exploitation.

The Washington Hospital Center aspires to the ideals of

developing into a truly teaching hospital. Until better criteria are established it cannot be stated how far it has developed in that direction but such is the goal of its board of trustees, its administrator and most important of all, its professional staff. Sometimes the activities of these three groups, with somewhat different interests and experience, go in different directions in an effort to provide the best possible care to the patients and at the same time conduct a teaching hospital. One of the duties of a Director of Medical Education is to direct them toward the goals of a good teaching hospital which by definition should automatically provide the best in medical care.

An individual, however, does not make the hospital a teaching institution. One of the present misconceptions is that all a community hospital needs to make it a "teaching hospital" is to designate a staff member as the Director of Medical Education or the director of a residency program, or to employ someone with or without previous experience or qualifications as a full-time director of education. A hospital will become a teaching hospital when, and only when each member of its active staff performs his teaching duties in a coordinated program similar to that in an undergraduate school. It cannot be obtained by just thinking or talking about it or just going through the motions without interest and enthusiasm. Likewise it cannot be accomplished by each member of the staff selfishly conducting his own independent pet teaching program without consideration for the graduates' needs. Teamwork, sacrifice and a common interest and goal are important qualifications for a teaching staff. They are not found in the staffs of many community hospitals where the dominant characteristic is self-interest and unfulfilled teaching obligations and where the criteria in joining a staff are what will the hospital do for me rather than "what can I do for the hospital?"



patients

Patients prefer are happier
the greater
when doctors
of administration and
comfort of FLEET Choose
ENEMA as compared to old-style
enemas. The ready-to-use squeeze bot-

tle eliminates troublesome preparation and cleanup—while insertion is made easier and safer with the pre-lubricated, anatomically correct 2-inch rectal tube.

tomically correct 2-inch rectal tube. Disposable feature insures a sanitary enema solution each time. And FLEET ENEMA works better with its 4 fl.oz. of precisely formulated solution than

one to two pints of soapsuds enema! Choose FLEET ENEMA next time an enema is indicated—for optimal convenience, effectiveness and safety. 100 cc. contains 16 Gm. sodium biphosphate and 6 Gm. so-

bottle. Pediatric size, 2¼ fl.oz. squeeze bottle. Pediatric size, 2¼ fl.oz Also available: FLEET OII RETENTION ENEMA, 4¼-fl.oz ready-to-use unit containing Mineral Oil U.S.P. Available at all pharmacies.

C. B. FLEET CO., INC. Lynchburg, Virginia

Here's a golden opportunity to get paid a salary where there's little opportunity to spend it.

Camp MDs Wanted Now!

If you think a camp doctor might be a good spot for you this summer, get started now. Camps hire ahead of time; they're filling July through August positions.

Camps are looking for physicians for the summer months. Even if you have only a few weeks vacation coming, it can still work out. Here's how: many camps allow what they call a "split season," taking on one resi-

dent who guarantees them a replacement from among his colleagues to finish out the season. You can team up with another resident and stagger your vacation times to give full season coverage to one camp.

Where to find openings:

- Your hospital's bulletin board. Some camps send out notices to hospitals in their areas as early as February, others not until April or May.
 - · Your local medical society



135 mea ste

In the acid m the fas stoma Medul essent - only Modro hours Hower the du (appre pH of 90 to the M releas

perior

Bach Medro Suppli and 1: Medro

The

135 tiny doses mean smoother steroid therapy...

In the relatively acid medium of the fasting stomach, Medrol Medules remain essentially intact - only 5% of the Medrol content is released after 2 hours at pH 1.2. However, in the environment of the duodenum (approaching a pH of 7.5), from 90 to 100% of the Medrol is released over a period of 4 hours. Slow Release



Slow Absorption



pH 7.5

Sustained Action

Each capsule contains:
Medrol (methylprednisolone) . . . 4 mg.
Supplied in bottles of 30
and 180.
Medrol hits the disease,

but spares the patient.



The Upjohn Company, Kalamazoo, Michigan

in acute allergic disorders:

Judged to be "a nearly ideal formulation," Medrol Medules gave good to excellent results in 25 of 28 children with various acute allergic disorders. "There were no serious side effects and minor complaints were reported in only two patients." The author also found that "there is a definite advantage for Medrol Medules inasmuch as much smaller doses seem able to produce full clinical relief...."

Indications and effects
Medrol benefits (anti-inflammatory,
antiallergic, antirheumatic, antileukemic, antihemolytic) have been
demonstrated in acute rheumatic carditis, rheumatoid arthritis, asthma, hay
fever and allergic disorders, dermatoses,
blood dyscrasias, and ocular inflammatory disease involving the posterior
segment.

Precautions and contraindications
Because of Medrol's high therapeutic
ratio, patients usually experience dramatic relief without developing such
possible steroid side effects as gastrointestinal intolerance, weight gain or
weight loss, edema, hypertension, acne,
or emotional imbalance.

As in all corticotherapy, however, there are certain cautions to be observed. The presence of diabetes, osteoporosis, chronic psychotic reactions, predisposition to thrombophlebitis, hypertension, congestive heart failure, renal insufficiency, or active tuberculosis necessitates careful control in the use of steroids. Like all corticosteroids, Medrol is contraindicated in patients with arrested tuberculosis, peptic ulcer, acute psychoses, Cushing's syndrome, herpes simplex keratitis, vaccinia, or varicella.

1. Dugger, J. A.: J. Michigan M. Soc., 59:1812 (Dec.) 1960.

Medrol* Medules

*Trademark, Reg. U. S. Pat. Off.



- 1. LICENSE. Is a license needed in the state where the camp is located?
- 2. ASSISTANT. Will you have an assistant? Many camps will have a nurse on the payroll. Some will provide a counselor to help.
- 3. CONSULTATION. Are there hospital facilities in town? What arrangements has the camp made with the hospital? Is there a local physician available to help you when needed for consultation? Have arrangements been made for you to hospitalize a seriously ill child?
- 4. DISPENSARY. What are the facilities of the dispensary? How well is it equipped? Will your recommendations be accepted as to the needed supplies of the dispensary?

- 5. SPECIAL CARE, Must all children have physical examinations by their private physicians prior to their acceptance by the camp? Will the camp knowingly accept diabetics, allergic or cardiac children (requiring constant and specialized care)? If so, will you be responsible for their maintenance therapy and management?
- 6. COVER. Here are important items which should be settled in advance! What are your days off, if any? Will you have anyone to cover?
- 7. WIFE. Are there facilities for your wife and family? By and large, camp directors consider the camp physician's wife a problem-unless she is willing to help out in some small way with the camp's activities. Camp directors will usually offer her some job

as assis crafts \$ some si pay her

salary? camps vary f 10-wee

9. other sional staff? physic

> 10. covere not, w practi the di

> > culat won' you nam cam ning

> > > May

frequently will get requests for ment agencies in your area. Many camp physicians. A telephone camps list with the same agency call to the society or a careful year after year. The agency can help you evaluate the setup. look-through of the classified sec-• The Sunday supplements tion in the society's journal may and classified sections of metroturn up something. · Established physician place-

politan newspapers.

OUT MMER CAMPS

Ill

20

to

III

s,

2

0,

1-

nt

if

9

is

į.

a

as assistant to a counselor, arts and crafts supervision, picnic manager, or some such position—and are happy to pay her for her efforts.

- 8. SALARY. What is the exact salary? (Is there a contract?) Most camps figure your pay by the season, vary from \$500 to \$900 for a 7- to 10-week season.
- 9. DUTIES. Do you have any other duties besides strictly "professional care" of the campers and camp staff? Some camps try to have their physicians double as nature counselors.
- 10. MALPRACTICE. Are you covered by a malpractice policy? If not, will the camp pay for such a malpractice policy if you take one out for the duration of your camp job?
- National and "family" circulation magazines. While there won't be ads for camp physicians, you can get a good list of camp names and addresses. (Also see camp ads in this journal beginning on page 173.

It may prove a good shortcut to write directly to the camp association headquarters, requesting information about physician openings in any of their summer camps.

One big national group, the American Camping Association, maintains headquarters in Martinsville, Indiana and has regional or district offices located around the U.S. for placement of camp counselors, nurses and physicians.

Their publication, "Directory of A.C.A. Member Camps," (50c) gives a brief description of the several hundred approved camps in the U.S., Canada, Alaska, and Hawaii. Information includes the major camp activities, population, age groups, and key personnel. Try your local library for a copy.

Shopper

Since camps are having quite a bit of difficulty in getting doctors, you're in a shopper's market. Don't jump at the first salary offer (unless you are completely satisfied, of course). You may be in a position to negotiate a bit, especially now when some camp directors are concerned about getting an MD in time for a June or July camp opening date. Perhaps you might suggest

WANTED:



What do summer camp directors expect of a physician? One expressed it this way: "First, I want a man who is professionally qualified. Training references help us determine this, Second, personality really counts. Most people think of summer camps as vacation playgrounds, baby sitters away from home. In part this is true. But more important, we think, is our educational responsibility, helping the child toward emotional maturity-teaching him to accept responsibility for himself and others. This is where the physician's personality comes in. If he is really interested in the children, he gives them confidence, guides them away from an over-concern about minor cuts or temporary malaise. In short, he helps them grow up. This doesn't require a grim scientist - simply an affable, outgoing human being who is competent and interested in the children under his care. We ask the same of our counselors: Competence, common sense, and interest in the children."

a higher figure and then work back to a compromise.

Or, if the camp is particularly desirable from your point of view, work on a few possible fringe benefits which have not been offered; such things as your wife's job, or maintenance for your family, your days off, etc., are good extras. Be sure to arrange for such things as salary and time off and equipment before you sign any contract.

Although summer camp can be a refreshing experience after a long year in your hospital, it isn't necessarily "easy livin'." trai ALI

byp

Mo

cen

mo

AL

rho

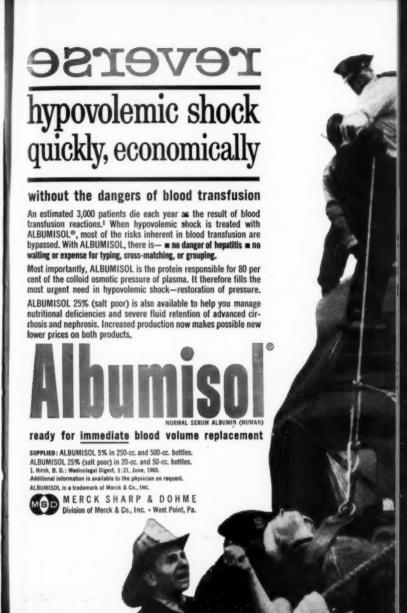
low

Experience

Here's the view of a veteran camp physician, Dr. Louis J. Polskin:

"Are a few weeks spent at a summer camp as camp physician a carefree reprieve from professional responsibility? Not by a long shot. In fact, such an assignment might favor more toil than free time. But, you'll be almost guaranteed less tension and far more relaxation than is possible during a comparable period spent in your hospital training.

"As camp doctor, you will face all problems of modern youth from bed-wetting, in the very young, to broken hearts among



ork

arly iew, nge of-

fe's our are

ime wou

be a it

an J.

t a ian

asoil be

is be-

ce th ry

an

teenagers. You may also find yourself with a small adult practice which might include indigestion among the kitchen help and hypertensive headaches, popular among directors.

"But the happy note to remember is whether treating a laceration. athlete's foot. mumps, you will be in a healthy, active situation. And though dispensing the same brands and shots you handle in your hospital, you'll be in an airy infirmary. This is camping—and it is healthful, rejuvenating and lots of fun.

"Definitive treatment pertinent to fractures, snakebite, suturing, unresolved fevers and illnesses is not intended in a camp infirmary, and logically, is transferred to the town physician." (Nearly all camps provide broad medicalsurgical insurance for their personnel and campers to assure them maximum care.)

Salary

What salary to ask? Well, you'll never receive what you'd earn in private practice! Since the camp nurse receives \$50-\$75 per week, Dr. Polskin (who has had four "summers" of camp "doctoring," each "summer" being four weeks only) is of the opinion that a fair salary should be not less than three times the nurse's stipend. Camps sponsored by charitable organizations offer much less.

Younger

Dr. Polskin states:

"Even if it may prove to be a "quasi" vacation, you'll be tanner and healthier when you come home. Somehow, when the first signs of spring appear each year, I begin to look forward to renewing acquaintances with those pestering, sniffling rock-'n-rollers! I think you will, too.

"You will look back on the lectures in accident prevention and hygiene you extemporized, the phone calls from frantic parents, several hundred miles away, the participation in the camp sing, orchestra, dramatics, or in the teaching program of the camp. You will recall your cautious moments on the tennis courts, in a canoe, or in the swimming hole.

"And you're sure to find out how really 'tired-blooded' those sedentary muscles have become!

"But you will come home brighter and younger because you were with the young."

See "Camp Physician" openings on page 173.



anorectal comfort in minutes

for full symptomatic relief from the discomforts of hemorrhoids, proctitis and pruritus ani

start therapy with ANUSOL-HC, 2 suppositories daily for 3 to 6 days, to reduce inflammation, relieve pain and itching, shorten total treatment time. Then, maintain patient comfort with regular ANUSOL, 1 suppository morning and evening and after each evacuation, to prevent recurrence of symptoms.

Neither Anusol nor Anusol-HC contains analgesic or anesthetic agents which might mask symptoms of serious rectal pathology.

anusol

hemorrhoidal suppositories and unguent

anusol-HC

hemorrhoidal suppositories with hydrocortisone acetate, 10 mg.

the uld the on-

ne rst ar, re-

rs!

end ne

s, ne

g,

1e

p.

IS

n e.

ıt

e

e u

Here's how to make your checkbook do triple duty.



Tips on Handling Your Checking Account

Wilburn L. McClure, Jr.

For most house staff physicians, a checking account *should* provide three advantages:

- 1. Convenient way to pay bills.
- Simple means to keep track of income and expenditures.
- 3. A basis for rapidly calculating deductible expenses for income tax purposes.

Should provide . . . but unfortunately, items 2 and 3 are seldom attained.

Whether you or your wife handle the checkbook, confusion at the end of the month is probably the rule. No matter how meticulous you try to be, when you begin the job of reconciling your cancelled checks against your checkbook balance and the bank's balance, you generally are hoping:

- You won't find a cancelled check which you forgot to enter—thus reducing the amount you thought you had as a balance.
- The bank report will show you have more money in the

On

nat

On

mi

Ne

the

The author is the consultant in charge of the Baltimore, Md., office of Professional Business Management, Inc.

all it takes for sustained protection in asthma



all-day and all-night relief from asthma symptoms

New Ted

Sustained Action antiasthmatic

One tablet on arising-protects through the working day, virtually eliminates the need for emergency medication

One tablet 12 hours later-lets the patient sleep, reduces the need for middle-of-the-night emergency medication

New Tedral SA protects against bronchial constriction and reduces mucous congestion throughout the day and night, increases vital capacity and ability to exhale, reduces the frequency and severity of asthmatic attacks. Patients get the benefits of sustained protection with the convenience of b.i.d. dosage. New Tedral SA is particularly indicated for patients who need continuous medication over prolonged periods.

RECOMMENDED ADULT DOSAGE: 1 tablet on arising, 1 tablet 12 hours later. PRECAUTIONS: Tedral SA should be used with caution in patients with cardiovascular disease and/or severe hypertension, circulatory collapse, hyperthyroidism, prostatic hypertrophy or glaucoma. Phenobarbital in the formula may be habit forming.

EACH TABLET CONTAINS: Theophylline...180 mg.; Ephedrine HC1...48 mg.; Phenobarbital...25 mg.

Tedral SA is available to your patients on prescription only.



ife on b-

WC

en

ng

ıst

he

re

ed

er

u

W

ENVELOPE SYSTEM

By keeping receipts and bills and cancelled checks in your check-book, you may find you've taken on more bulk than you have room for. An alternate method is to keep your receipts, bills and matching cancelled checks in envelopes, using one envelope for each month's accumulation. After 36 months have passed, you can retire the oldest month's envelope; except for fraud or by mutual consent, the Internal Revenue can't go back beyond three years.

bank than you thought you had.

The latter rarely happens. The former too often does.

Also, in at least one month out of three, your excitement as you add the figures, anticipating a perfect balance, is shattered when you find you're off (by some ridiculous figure such as \$2.43 or \$.81).

And as for your record of deductible expenses, few house officers realize that the Internal Revenue Service does not always consider a cancelled check as proof of an expenditure.

Since the burden of proof for legitimate deductible expenditures always rests with the tax-payer, a receipted bill or can-

celled check with a bill attached is the best evidence you can present when and if your income tax return is called up for an audit. (The Internal Revenue Service is performing more and more audits each year.)

Here then is a simplified checkbook and accounting procedure which is recommended for staff physicians who have a limited number of deductible business expenses:

- 1. Obtain the large, three checks to a page, business-type checkbook from your bank. Unless the checks are personalized there is usually no charge made by the bank for this type of checkbook.
- 2. Make sure you deposit all cash and checks into your checking account. This gives you a positive record of all income—other than interest on savings, and those dividends which are credited to your brokerage account.
- 3. Insist on bills or receipts for every item paid for out of your checking account.
- Mark all check stubs with adequate information describing the purpose for which the check was drawn.
- 5. When writing and numbering a check, place the same number upon the bill or receipt and place this bill in the back of



new therapeutic light on "sinus" headache

"sinus" or frontal headache and congestionwhether from true sinusitis or rhinitis-yield promptly to Sinutab. In therapy or prophylaxis Sinutab rapidly and effectively aborts the pain, decongests the mucosa and relaxes the patient. Verify the value of Sinutab for yourself: you and your patients will be pleased.

led reme urvore

ed 0ed

ole

ee pe ned de

of

ill k-

)er d 1t.

ts

of

h

g k

for sinus and frontal headache Sinutab



Write the Check Right!

1. Write legibly.

Date the check the day it is written. Checks dated on Sundays or holidays are valid.

 Fill the "pay to the order of" line fully. Any blank space at the end of the name should be filled with two or three parallel ink lines,

4. Use ink. Pencil is perfectly legal, but is very easy for anyone to alter.

Don't cross out, erase or change anything on the check,

more I

DIURI

of chlo

Dosage

DIURII

One 2!

tablet

6. Make sure written amount agrees with numerical amount.

7. Start the amount line at the extreme left edge of the check and leave no space between words. As with (3) above, fill in the line completely by drawing parallel lines from the last word, across to the end of the line.

the checkbook temporarily. (See above.)

6. When the cancelled checks are returned from the bank, attach each check to the appropriate stub with scotch tape. Then, from the back of the checkbook, take the bill or receipt for which the check was written and attach it to the cancelled check.

If these simple steps are carried out, an Internal Revenue audit can be conducted quickly and accurately, and a great deal of confusion can be avoided when reconciling expenditures. (A duplicate system should be used where separate bank accounts are maintained for the home or other business accounts, such as rental properties.)

This method will work well for you while in training. It will also operate equally well in keeping accounts for a limited private practice.

"Congratulations, you've been selected this month to pay your bill . . . "



in edema or hypertension

more doctors are prescribing-

more patients are receiving the benefits of—
more clinical evidence exists for—



ange

ount

exand As

om-

of hen dused ints

or

for

Iso

ing

ate



than for any other diuretic-antihypertensive

DIURIL is unique. There is no other brand of chlorothiazide.

Dosage: Edema—One or two 500-mg, tablets DIURIL once or twice a day. Hypertension—One 250-mg, tablet DIURIL or one 500-mg, tablet DIURIL two to three times a day.

Supplied: 250-mg. and 500-mg. scored tablets DIURIL chlorothiazide in bottles of 100 and 1000.

DIURIL is a trademark of Merck & Co., INC.

Additional information is available to the physician on request.



MERCK SHARP & DOHME Division of Merck & Co., INC., West Point, Pa.













HYPERTENSION CONGESTIVE FAILURE PREMENSTRUAL TENSION EDEMA OF PREGNANCY. CIRRHOSIS WITH ASCITES RENAL EDE

"I found my two years in the Air Force a gratifying, enjoyable . . . experience."

In February 1958, I received orders to report for active duty as a medical officer assigned to the 4737th USAF Hospital in St. Johns, Newfoundland. My next contact with the Air Force was a friendly, nonofficial letter from my future hospital commander, welcoming me, advising me of the availability of base housing, and offering to be of help with any problems that I might have. This kind gesture was most welcome in my state of uncertainty about military life.

Assistance

After a four-week basic orientation course in Alabama, I was on my way to Newfoundland. The hospital commander and his wife awaited me at the landing strip and drove me to their quarters. After dinner, several other medical officers joined us for what was to be the first of many enjoyable evening get-togethers. The next few days were devoted to getting oriented in the hospital and around the base. I found

$\mathbf{S}_{\mathbf{ervice}}$ itl

the advice and help of the hospital commander's wife of great value in making arrangements for the arrival of my wife and children. The billeting and housing department supplied us with furniture to fill the gap until ours arrived, and the family assistance center took care of kitchen and dining room supplies, so that within a week my family was able to join me and establish normal housekeeping.

Hospital

I was placed in charge of the obstetric and gynecologic services of this 100-bed hospital. On my first inspection tour, I was delighted to find the most modern equipment in both the wards and clinics. The obstetric section was handling approximately 25 deliveries per month, but the gynecologic service was practically nonexistent. The building

cancer starte amina of fac were "Dail and 1 wome spons greate from scree wom malig gyne lishe grate by a

гарр

begin

May

T

up of first p

cussio

mande

cevith a Smile

15-

at

or il-

ng

II-

rs

ce

nd

at

le al

ne v-

n

as

1-

ds

n 5

ie C-

g

in

Kurt Bochner, M.D.

up of this service was thus my first problem. After several discussions with the hospital commander, a concerted cervical cancer detection campaign was started. The value of annual examinations and the availability of facilities for their performance were publicized by radio and "Daily Bulletin" announcements and by personal appearances at women's club meetings. The response and results were even greater than anticipated. Aside from the obvious benefits of screening approximately 1000 women and detecting five cervical malignancies in early stages, the gynecologic clinic became established, the base personnel were grateful for the interest shown by a "two-year visitor," and our rapport was excellent from the beginning.

The hospital commander was most cooperative in this matter

as well as with all problems which arose during my two years in the Air Force. Throughout this time, he proved himself to be the friend and counselor of the young medical officers.



The actual practice of medicine was gratifying and rewarding. The base personnel and their dependents were extremely appreciative for the medical care rendered to them, and it was pleasurable to hear their comments outside of the hospital. The little extras like starting a sterility clinic, showing labor films to antepartum patients, discussing sex hygiene with teenagers, and providing music in the labor suite, demonstrated a true interest in their welfare, and created feelings of trust and confidence among the base population. In return, invitations to join the pilots on flights to the United States and other reciprocal gestures were frequent.

Total Care

The physicians took turns at weekly hospital meetings in presenting talks about interesting medical problems, which arose on the respective services. We obtained medical motion pictures from various sources, and the Armed Forces Institute of Pathology supplied us with slide sets and clinico - pathologic conferences which served as nuclei for discussions. Last, but by no means least, there were the monthly social evenings for the hospital officers and their wives.

The civilian consultant in obstetrics and gynecology was a very capable individual and the most essential man in our department. With his aid, I was able to offer my patients total care and to perform the surgery for which they would otherwise have had to be evacuated to the United States. He also served as a liaison between myself and the local medical community, enabling me to meet with physicians, from the training centers of Great Britain and Canada, who were practicing medicine under circumstances that differed greatly from my own.

The nurses and corpsmen were courteous and cooperative. Their reliability was valuable in reducing the physicians' worries about the welfare of hospitalized patients.

Social

Social life on the base was friendly and plentiful. The Air Force community seemed like one large family, the bond of the uniform transcending all prejudicial lines. Wives formed friendships rapidly and were well occupied with club activities and service functions. The foreign goods at the base exchange were an unending source of attraction for them. The children were of-

the new high-potency multivitamin from Robins

oba the artble and ich nad ted son cal me the ain ing ces my

ere eir ucout

vas Air ike the

di-

id-

)C-

nd

gn

ere

on of-

ian



Adabee: for people on diets...

Added to dieting regimens, Adabee's authoritative quantities of A, B, C, and D vitamins help keep tissue levels up when food intake must be severely curtailed. And it serves up its basic nutrition without folic acid, or other extraneous ingredients of recently challenged rationality. If you have a patient on a diet, support him with Adabee. Each yellow, capsule-shaped tablet contains: Vitamin A, 25,000 USP units; Vitamin D, 1,000 USP units; Thiamine mononitrate (B₁), 15 mg.; Riboflavin (B₂), 10 mg.; Pyridoxine HCI (B₄), 5 mg.; Nicotinamide, 50 mg.; Calcium pantothenate, 10 mg.; and Ascorbic acid (vitamin C), 250 mg. Or if you prefer, there's Adabee. M with its eight minerals.

THE RESIDENCE OF THE PARTY OF T

A.H.Robins Company inc. Richmond, Va.

fered excellent educational facilities in modern grade and high schools, staffed by American teachers. Little league ball clubs, scouting activities, and similar functions created a smalltown U.S.A. atmosphere for them.

In conclusion, I found my two years in the Air Force a gratifying, enjoyable, and maturing experience. My numerous memories include the presentation of a scientific paper before the Newfoundland Medical Association, my service as hospital social chairman, and my favorite "War Story" about the winter night when I was stranded during a blizzard in an ambulance, after making an attempt to respond to a labor call.

I had numerous questions, fears, and doubts before entering military service, and the reports which I received did not clarify matters. Since I have been confronted with similar queries after my recent return to residency training, this article was written for those physicians whose service lies ahead of them. As for advice, I offer the following:

1. Enter into active duty with a smile and not as a martyr.

2. Give of yourself as you would in private practice.

now

th

an

co

Take an active part in hospital and base activities.

 Overlook the minor annoyances which are inevitable in all huge organizations.

5. Above all, do not "knock" military life. Your patients and their dependents have selected this as their way of life, and they do not like to hear criticisms and complaints from "two-year visitors."

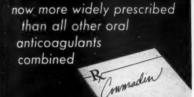
For \$10 . . . How's Your Sense of Humor?



Unlimited opportunities for house staffers who can see the humor in hospital training situations, and can visualize a cartoon for the situation. Please tell about your cartoon idea (a drawing is not necessary, but please include a description and a gag line) in a note to: Cartoons, Resident Physician, 1447 Northern Boulevard, Manhasset, L. I., N. Y. If your idea is accepted as the subject of a cartoon, you will receive a guick ten dollars.

COUMADIN

the proven anticoagulant for long-term maintenance



ify onter

rv-

for

ith

ou

OS-

OV-

all

k"

ind

ted

nev

ind

vis-

ho

ns.

on.

is is

ion

ent

set,

ect

Irs.

cian

152,000,000 Over 131,000,000 doses administered to date



Over 125 published papers since 1953

the original and only warfarin responsible for establishing this drug as closely approaching the ideal anticoagulant.^{1,2}

1. Baer, S., et al.: J.A.M.A. 167:704, June 7, 1958. 2. Moser, K. M.: Diseasea-Month, Chicago, Yr. Bk. Pub., Mar., 1960, p. 13.

Full range of oral and parenteral dosage forms —

COUMADIN* (warfarin sodium) is available as: Scored tablets—2 mg., lavender; 5 mg., peach; 71/2 mg., yellow; 10 mg., white; 25 mg., red. Single Injection Units—one vial, 50 mg., and one 2 cc. ampul Water for Injection; one vial, 75 mg., and one 3 cc. ampul Water for Injection.

Average Dose: Initial, 40-60 mg. For elderly and/or debilitated patients, 20-30 mg. Maintenance, 5-10 mg. daily, or as indicated by prothrombin time determinations.

*Manufactured under license from the Wisconsin Alumni Research Foundation.

Complete Information and Reprints on Request

Endo

ENDO LABORATORIES Richmond Hill 18, New York

Hospital Administration and Medical Education

"The administrator renders a significant service when he contributes to the development and support of a highly qualified medical advisory team which capably plans and implements the programs of medical education most suitable in meeting the needs of the hospital and the community it serves."

Eugene E. Tillock, Ed.D.

The modern hospital is a product of the scientific and technical advances of our time. It has developed to the point where it offers life, hope, and the assured promise of assistance to those who seek its services. It presents the sharpest contrast when compared to those institutions called hospitals in earlier centuries as

well as those of recent decades because of the wide differences in knowledge, practices and capabilities which have evolved and continue to improve to the limits of man's imagination.

The voluntary hospital has evolved as the predominant type of hospital in the United States. The basic principle of the voluntary hospital entails support of the hospital by the community which it serves on a non-profit

from the rol and the proare open corpor profit, a tals, op Federal a communications.

Inpatie

as an incontinu (b) co (registe or the adequa such a technol titians,

departi practic hospita distinct sional partme tial di work j sonnel

A the he cilitate nation the he

Physician May 1

Dr. Tillock is Assistant Director, Highland View Hospital, Cleveland, Ohio.

basis. Other types of hospitals from the standpoint of the control and ownership aspects are the proprietary hospitals which are operated by individuals or corporations principally for profit, and governmental hospitals, operated by local, state or Federal units of government, or a combination in special instances.

Inpatient center

D.

les

es

a-

nd

its

as

pe

S.

n-

of

ty

fit

ın

A hospital has been defined as an inpatient center with "(a) continual physician services, and (b) continuous nursing services (registered or licensed practical, or the equivalent) and other adequate paraphysician services such as technicians, therapists, technologists, biochemists, dietitians, and others.¹

The classification of hospital departments varies with local practices and the nature of the hospital. There is generally some distinction made between professional and non-professional departments because of the essential differences inherent in the work performed by hospital personnel in these areas.

A functional organization of the hospital by departments facilitates the control and coordination of the many services of the hospital so that the administrator and all department heads, clinical and service, professional and non-professional, may effectively facilitate the provision of the best care possible for the benefit of the hospital patients.

Professional departments are those generally associated with the provision of direct and indirect care of patients. Other departments fall into a classification of general service departments. General service departments provide the basic services essential to management and maintenance of the organization as a unified entity so that it might effectively fulfill its objectives and purposes.

Varied structure

The modern hospital is faced with increasing complexity of organizational structure as the advancements in science and technology add new specialty groups to the gradually expanding force of personnel required to provide even those services considered to be basic to proper patient care.

The organizational structure of almost all hospitals will vary with factors of individuality so that an identical plan for coordinating basic functions is neither a reality or a practicality. The organization chart is a common tool for planning the delineation of functional departmental responsibility and the designation of formal relationships with corresponding lines of authority.

No single plan

The diverse patterns of organization and administration evident in hospitals in the United States precludes the possibility of a single plan which can meet the special circumstances governing the operation of each hospital or of the communities served by various hospitals.

Learn mechanisms

Professional and non-professional persons newly oriented to hospital activities will often fail to understand the reasons for the complex patterns of hospital organization structure and the relationships of its constituent units in carrying out the total hospital program. In numerous instances it has been demonstrated that there is an impairment of effectiveness of performance of these persons until such time as their personal grasp of technical and human aspects of the hospital organization is realized. It is essential for any physician or medical student to learn about the major functions of the hospital and the mechanisms through which these functions are coordinated.

An indication of the possible need for hospital administrators to provide for comprehensive programs about hospital administrative affairs for members of their medical staffs was proiected by Gottlieb, who reported that the levels of knowledge of hospital administrative affairs among medical staff members generally are not very high, and that knowledge of personnel administration and financial management was rare in two hospitals in which he conducted studies.2

Personal relationships

Professional groups appear within the hospital organization in an ever broadening sphere which dwarfs the familiar and traditional roles of nurses and physicians. Hospital administrators are acutely aware of the status and prestige factors with which they must cope in their daily activities involving the newest and the older professional specialties. These interpersonal relationships are governed somewhat by tradition and the modifications brought by the contemporary professionals who seek firm roots in the informal if not formal organization structure of

the hoperson medica profess collaborates demic inter-collaborates inter-collaborates and the hoperson medical profession demic inter-collaborates and the hoperson medical profession demical profession de

Basic

Ad

means
deterr
stituti
admir
fulfilli
for th
basic
MacI
the
care
educa
and
healt
prom

pital objenific pete istra hosp tion avair

tific

T

the hospital. It is fortunate that personnel in the newest of the medical, scientific and technical professions are usually geared to collaboration with the other professions as a result of their academic preparation for work in an inter-disciplinary setting.

Basic hospital goals

co-

ssible

ators

nsive

ad-

nbers

pro-

orted

ge of

ffairs

bers

and

l ad-

nan-

ospi-

icted

pear

tion

here

and

and

stra-

the

with

heir

ew-

onal

onal

me-

odi-

on-

eek

not

of

cian

Administration presents the means for carrying out the predetermined objectives of an institution. The goal of hospital administration is to facilitate the fulfillment of the basic reasons for the hospital's existence. These basic objectives are outlined in MacEachern's vital functions of the hospital as follows: "(1) care of the sick and injured; (2) education of physicians, nurses, and other personnel; (3) public health; prevention of disease and promotion of health; and (4) advancement of research in scientific medicine."3

The effectiveness of the hospital in accomplishing its stated objectives will depend to a significant degree upon the competence of the hospital administrator, the policies governing hospital functions, the organization structure and the personnel available to carry out essential functions. Hospital administrators have gained professional

status through development of their vocational specialization which of necessity requires a high degree of knowledge and skill in the use of the art and science of management in their direction of hospital affairs.

Administrators prepared

With increasing frequency administrators prepare for their positions through completion of graduate programs in hospital administration. These programs provide a year of academic training in addition to an administrative residency under a preceptor who is successful administrator of a hospital normally fully accredited by the Joint Commission on Accreditation of Hospitals.

The hospital administrator actively aids the continuing development of the organization through support of established hospital policies as well as through recommending new or modified policies to the Board.

The Board of Trustees is the only legal governing authority of the hospital with the ultimate moral and legal responsibility for the policies and operations of the institution. Board members generally serve without compensation and they are selected from representative leaders of the community served by the hospital.

Policies recommended

The hospital administrator may initiate recommendations directly or channel them to the Board of Trustees by way of the medical staff organization or through the representatives of the hospital Joint Conference Committee, which provides for combined representation of the Board of Trustees, the Medical Staff and the Hospital Administration.

Other policy recommendations are developed by the administrator in cooperation with department heads in staff or advisory positions, as well as those in line or operating departments of the hospital.

Policy direction of the institution will tend to define the essential functions of the hospital and place emphasis on the primary objectives upon which concentration of the highest priority will be designated.

Administrators of highly rated teaching hospitals appear to support the viewpoint that placement of special emphasis on educational functions does not detract from the excellence and direction of patient care but instead facilitates the attainment of superior standards of patient care. The modern hospital is in the advantageous position of being able to utilize its facilities on a broad

base while fulfilling its essential role in the education and training of medical and allied health professionals and providing a high level of comprehensive care to patients. The administrator is in a key position of leadership to exert favorable influence in support of the programs of medical education which are proposed for the hospital.

Education through service

The traditional primary emphasis on the care of the patient is preserved if the perspective is taken that all medical education presents an immediate as well as long-term benefit to patients served. The administrator has an obligation for supporting and encouraging medical education in its broad forms within the limitations of a reasonable balance between the operating needs of the hospital and the additional resources which may be made available for educational endeavors.

It may be generally agreed that any hospital worthy of the name conducts some forms of medical education through the routine services offered to patients.

The administrator renders a significant service when he contributes to the development and support of a highly qualified medical plans gram suital the l

that may inter

> "Ord (Nov 2. Do D

advisory team which capably plans and implements the programs of medical education most suitable in meeting the needs of the hospital and the community it serves.

itial

ning

-OTO

nigh

to

s in

to

sup-

ical

for

em-

ient

e is

tion

l as ents an enin itabethe reade en-

hat me ical ine

triupical

cian

Finally, it should be recognized that the hospital administrator may frequently best serve the interests of his hospital and the medical education to be conducted therein through skillful performance of his basic management function. This function encompasses features of an arbitrator, a catalyst, a creative planner, and a leader of people whose forte is based on the genuine practice of principles of good human relations.

Bibliography

- Don Chill and Alan E. Treloar, "Ordered Definitions," Hospitals, XXXII (November 1, 1958), 43.
- 2. Symond R. Gottlieb, "How Much Do Doctors Know About Hospitals," Hos-
- pitals, August 1, 1958, part 1, p. 102. 3. Malcolm T. MacEachern, Hospital Organization and Management (third edition revised; Chicago: Physicians' Record Company, 1957), p. 29.



"Wouldn't an autopsy help diagnose my case?"

Key Words for the Clinic

In many areas of the U. S., foreign-born comprise a large part of the total population. Hospital physicians when examining and treating foreign-born patients, many of whom speak little or no English, often encounter serious difficulty in communicating even the most routine request or direction. The result is not only frustrating for doctor and patient, but a misunderstanding can endanger the proper care of the patient. To ease the patient's anxiety and assist the physician in conducting an accurate examination and history-taking, RESIDENT PHYSICIAN has prepared this guide to commonly-used medical directions, questions and answers, with translations into various foreign languages.

Using the language guide

Keep this language guide open in front of you while attending your patient. If a word doesn't seem to be understood, repeat it a few times slowly; vary the pronunciation slightly until the patient indicates his comprehension. The fact that you are trying to speak to him in his native language will cause your patient to be more relaxed and responsive. Grateful for your effort, he will be anxious to do everything he can to comprehend and convey accurate, precise information.

FOR EX

Yid

Yiddi languag from th Central written in its v

> nunciat which, sound Yiddis shadin unders word j Englis

RESI

Basic

Yiddis

find the

ch (th

Anate

hea eye ear

May

Yiddish-Speaking Patients

Yiddish may be more accurately termed a dialect than a language. Developed under Hebrew and Slavic influence from the High German, Yiddish is spoken by Jews in Russia, Central Europe and here in the United States. Since it is written in Hebrew characters, it is seldom seen in this country in its written form. And because it is a dialect, there are many variations, no absolute rules for pronunciation.

RESIDENT PHYSICIAN has attempted to indicate the pronunciation of each word by making up a word in English which, when spoken aloud, should closely approximate the sound of its Yiddish equivalent. Keep in mind that the Yiddish-speaking person is accustomed to hearing many shadings of pronunciation of Yiddish words; he will readily understand your meaning if you pronounce each made-up word just as you would pronounce it if it were a part of the English language.

In the United States, hundreds of thousands of Jews speak Yiddish and one other foreign language. The resident may find that by working back and forth between the two, he will be able to make himself understood with less difficulty.

Basic rules of pronunciation

ch (when italicized) is aspirated roughly in back of throat (there is no equivalent sound in English).

g is always pronounced hard, as g in go, get, great.

Anatomical terms

head	_	cup	lungs		loongen
eyes	_	oigen	shoulders		ahxel
ears	_	oiren	back	_	playtses

ian

nose — nuz mouth — moil hands — hant teeth — tzayner bladder — blahzer tongue — tzoong leg (bone) — bine throat — gorgle feet — feese finger — finger bowel — boych neck — haldz stomach — muggen chest — broost buttocks — toochess heart — harts womb — gabarmooter						
teeth — tzayner bladder — blahzer tongue — tzoong leg (bone) — bine throat — gorgle feet — feese finger — finger bowel — boych neck — haldz stomach — muggen chest — broost buttocks — toochess heart — harts womb — gabarmooter	nose	_	nuz	arm	-	orm
tongue — tzoong leg (bone) — bine throat — gorgle feet — feese finger — finger bowel — boych neck — haldz stomach — muggen chest — broost buttocks — toochess heart — harts womb — gabarmooter	mouth	_	moil	hands	_	hant
throat — gorgle feet — feese finger — finger bowel — boych neck — haldz stomach — muggen chest — broost buttocks — toochess heart — harts womb — gabarmooter	teeth	_	tzayner	bladder	_	blahzer
finger — finger bowel — boych neck — haldz stomach — muggen chest — broost buttocks — toochess heart — harts womb — gabarmooter	tongue	_	tzoong	leg (bone)	_	bine
neck — haldz stomach — muggen chest — broost buttocks — toochess heart — harts womb — gabarmooter	throat	_	gorgle	feet	_	feese
chest — broost buttocks — toochess heart — harts womb — gabarmooter	finger	-	finger	bowel		boych
heart — harts womb — gabarmooter	neck	_	haldz	stomach		muggen
	chest	_	broost	buttocks	_	toochess
	heart	_	harts	womb		gabarmooter

Courtesy phrases

Note: Mr., Mrs. and Miss (in their English form) are to be used, but normal courtesy also requires the use of the name after the title, if it is known. If the name is not known, the title is best omitted.

Good morning	goot morgen
Good afternoon	gooten tug
Good night	goote nahcht
Please sit down	bitte saitzen see seech
How are you	vee gait ess
Very well, thanks	ah dunk
Do you understand	varstait eer
I understand	eech varstay
Excuse me	enshooldigd
Very good	sair goot
Today	haint
Tomorrow	morgen
Yesterday	gestern

Directions to patient

too vee eech too
zite ruhig
zite mahr ruhig
affent eere moil
affent eere oigen
ahtemt teef
ahtemt doorch eere moil
hult eere ahtem

push coup plea Gener do p

whe

who

hov

hov

how how how

me sca chi sm pn typ en U.

He tra

E;

May

push cough please don't move kvetch hoost bitte hahlten see still

een zint krank

General questions

do you feel sick
do you have pain
—much pain
—mild pain
where
here
when
how many years
how many days
how many hours
how many times
where you you born
how old are you

es toot oich vey
ah sahch veytog
ah bissel veytog
a-voo
duh
van
veefeel yurin
veefeel tag
veefeel shtoondeh
veefeel mohl
voo zint eer geboiren
vee ohlt zint eer

Diseases

oter

used.

r the

best

ysician

measles scarlet fever chicken pox small pox pneumonia typhoid fever enteritis U.R.I. muzlen scarlatina heener pocken steln pocken loongen entzeending teephoos kishke entzeending cult

Systemic inquiry

Head trauma unconscious did you faint are you dizzy headache Eyes clear vision

voond gechalisht hut eer gechalisht es shveendelt oich cupvaitig

eer zaite klor

near far Ears

he is deaf noise in the ears

Nose coryza

did you have a nosebleed

Throat

do you have frequent sore-throat nunt vait

air ees toib

sih kleengt een dee oiren

dee nuz rinnt gagongin blutt fen nuz

hut eer oft haldz shmarzen

Genito-urinary

urine do you get up at night to urinate

does it burn chills fever vasser

shtate eer uf ba nahcht tzeeh lussen vasser

brennt ess kalt heetz

Pediatrics

did you have trouble with the child's delivery how are the child's stools

-constipated

—diarrhea

—how many a day
does the child eat well
any vomiting
does the child turn blue
does the child seem tired
does it hurt
it won't hurt
it will be over in a minute

do you want a piece of candy do you take the temperature what was the temperature hut eer gehut shvarikait meet dee keend's geboort wee ees de keend's shtoolgahng

—hart

—loysen muggen

—veefeel een ain tag
duse de keend ass goot
bracht de keend
weerd de keend bloy
ees de keend farmattert
toot ass vey
ass werd neecht vey tun
ass weerd zain ariber een ain
minoot

veelst dah ah shteekerl chokolat hut eer genoomen de temperature vus ees de temperature what what baby good

Gastro

do y do y are were do y

are did

wh

vel

bro do aft be

Card

die

do do

de

May

what a beautiful little girl what a big, handsome boy baby good see ees a shane madel air ees a shaner ingel klain keend goot

Gastro-intestinal

do you have a good appetite do you have a poor appetite are you nauseated were you nauseated do you vomit do you have diarrhea are you constipated did you have a B.M. today hut eer ah gooten appeteet hut eer ah shlachten appeteet feelt eer vee tzee brachen hut eer gafeelt vee tzee brachen bracht eer hut eer ah loysen muggen hut eer ah harten muggen hut eer gahut eere shtoolgahng

feces
black
white
yellow
brown
bloody
do you have cramps
after meals
before meals
did you have a laxative
did you take castor-oil

hut eer ah harten muggen
hut eer gahut eere shtoolgahng
haint
shtoolgahng
shvartz
vice
gail
brone
bluttick
hut eer krahmpfen
nuch dam assen
aider dam assen
hut eer ganummen ah opferung
hut eer ganummen reetzen oil

Cardio-respiratory

dee

ng

at

ure

cian

do you tire easily
are you short of breath
does your heart beat fast
do your feet swell
do you have a pain in the chest
—sharp pain

—sharp pain
—dull pain
do you cough
do you spit
sputum

vart eer meed shnall hut eer koorzen ahtem klupt eer harts shnall vayren dee feece gashvollen hut eer veytog in broost

—sharf veytog —neesht sharf eer hoost eer shpit shpyechtz bloody sputum have you lost weight does someone in your family have a cough

Obstetrics and gynecology

at what age did you begin to menstruate how many days do you flow 1 to 10

do you have a discharge
when was your last menstrual
period
are you pregnant
do you have pains with your
periods
how many times have you been
pregnant
how many children have you
had
how much did the largest weigh
what was the duration of labor

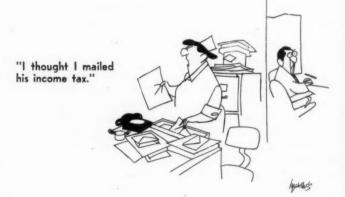
bluttickeh shpyechtz hut eer farloyren vug hut aymeetzer een eere familia ah hoost

vee alt gakreegen das monatleeche krahnkhait veefeel tag bluttekt eer ains, zwai, drai, feer, finef, sachs, seeben, ahcht, nun, zane

fleest eer
van gavaisen dus lattsteh
monatleeche tzite
eer shvangert
eer hut veytog meet dee monatleeche tzite
veefeel mul hut eer geshvangert

veefel keender hut eer gehut

veefeel hut dee graste gavoigen vee lahng hut gadeert dus huben



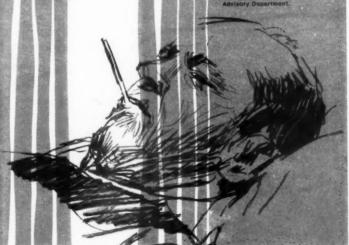
VITAMINS ARE THERAPY

STRESS FORMULA VITAMINS LEDERI

(herapeutic B and C vitamins rapidly restore essential nutrients lost during the acute phase, and help mobilize body defenses during convalescence, STRESSCAPS helps condition the body to respond to primary therapy. Packaged (30 and 100) in decorative "reminder" jar.

Each capsule contains: Each capsure contains:
Thismine Minonutrate (8): 10 mg.
Ribuftavin (8): 10 mg.
Nacinamide 100 mg.
Ascarbic Acid (0): 300 mg.
Pyrioszine HCI (8): 2 mg.
Vitamin 8): 4 mcgm.
Calolum Pantothenate: 20 mg.

Average dose: 1 to 2 capsules daily. Request complete information or indications, cosage, precautions and contrainmentations from your Loderte representative, or write to Medical Advisory Department.



chs.

ane

nat-

ert

n ben

cian

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.



Contest Answers and References

Comments on the recently completed Mediquiz Contest are still coming in—and the editors of your journal are pleased that so many contestants termed their increase in journal reading the "most valuable" aspect of the Contest.

Here is the answer and reference key for the complete series of questions, followed by a listing of the 50 answers and references to the tie-breaking series. All journals used as source material for questions are on the recommended journal list of the American Hospital Association.

On the opposite page, the question number precedes the letter designation for the correct multiple-choice answer. The abbreviated title of the source journal is followed by a series of numerals indicating, respectively, the volume and number of the source journal, and the beginning page of the article used as a reference for the question.

156

Se

5 E

May 1

August Issue

D A Source

- 1 C JAMA, 172:14:1465
- 2 B JAMA, 172:14:1502
- 3 A JAMA, 172:15:1577
- 4 C JAMA, 172:16:1734
- 5 B JAMA, 172:16:1764
- 6 C JAMA, 172:17:1875
- 7 D JAMA, 172:18:2057
- 8 E New Eng. J. Med., 262:14:687
- 9 D New Eng. J. Med., 262:15:748
- 0 A New Eng. J. Med., 262:17:846
- 1 B Surg. Gyn. Obs., 110:4:488
- 2 D Surg. Gyn. Obs., 110:5:527
- 3 D Lancet, 7134:1085
- 4 E Ann. Surg., 151:4:465
- 5 A Ann. Surg., 151:5:63
- 6 A Ann. Surg., 151:5:669
- 7 * Am. J. Med., 38:4:504
- 8 B Am. J. Med., 38:4:661
- 19 A Am. J. Med., 38:5:777
- 20 B Am. J. Med., 38:5:847

September Issue

Q A Source

- 1 A Surg. Gyn. Obs., 110:4:419
- 2 C J. Clin. Invest., 39:4:584
- 3 B Proc. Soc. Exp. Bio. Med., 103:4:836
- 4 C Ann. Surg., 151:4:567
- 5 E Lancet, 7128:1:790
- 6 E Am. J. Obs. Gyn., 79:4:789

- 7 D Am. J. Med. Sci., 239:4:487
- 8 A Arch. Derm., 81:4:516
- 9 D Arch. Neurology, 2:4:407
- 10 B Arch. Surg., 80:4:597
- 11 C Arch. Int. Med., 105:4:542
- 12 D Arch. Gen. Psychiat., 2:4:441
- 13 A J. Dis. Child., 99:4:
- 14 B Am. J. Med., 28:4:579
- 15 D Brit. Med. J., 5181:1226
- 16 C Brit. Med. J., 5182:1309
- 17 C JAMA, 172:17:1902
- 18 B JAMA, 172:18:2025
- 19 D New Eng. J. Med., 262:14:700
- 20 A New Eng. J. Med., 262:15:754

October Issue

Q A Source

- D Am. J. Ophth., 50:1:101
- 2 * Am. J. Ophth., 50:1:163
- 3 E Arch. Otolaryng., 72:1:152/136
- 4 A Radiology, 72:1:55
- 5 B Arch. Gen. Psychiat., 3:1:25/1
- 6 C Surgery, 48:1:111
- 7 A South. Med. J., 53:7:933
- 8 D J. Urol., 84:1:194
- 9 D Anesthesiology, 21:3:281
- 10 C Am. J. Path., 37:1:63
- 11 D J. Clin. Invest., 30:2:1176
- 12 A J. Clin. Invest., 30:2:1185
- 13 C Am. J. Obs. Gyn., 80:1:80
- 14 A Am. J. Med. Sci., 240:1:36
 15 B Am. J. Med., 29:1:84

ian

^{*} Full credit was given all contestants, regardless of answer checked, due to a defect in the question.

- 16 A JAMA, 173:11:1260
- 17 C Arch. Derm., 82:1:116/62
- 18 A Arch. Int. Med., 106:1:169/17
- 19 D New Eng. J. Med., 263:3:148
- 20 D New Eng. J. Med., 262:4:1226

November Issue

Q A Source

- 1 C J. Clin. Invest., 39:9:1353
- 2 C J. Thorac. Cardio. Surg., 40:3:321
- 3 B JAMA, 174:2:135
- 4 D Surg. Gyn. Obs., 111:3:259
- 5 E JAMA, 174:1:32
- 6 A JAMA, 174:3:226
- 7 D Am. J. Dis. Child., 100:3:59/341
- 8 A Am. J. Med., 29:3:508
- 9 E Arch, Surg. 81:3:379
- 10 B Ann. Surg., 152:3:518
- 11 D Brit. Med. J., 5200:694
- 12 C Brit. Med. J., 5200:721
- 13 C New Eng. J. Med., 263:9:423
- 14 B New Eng. J. Med., 263:12:569
- 15 E New Eng. J. Med., 263:12:579
- 16 C New Eng. J. Med., 263:11:531
- 17 C Ann. Surg., 152:3:343
- 18 A Surg. Gyn. Obs., 111:2:357
- 19 D New Eng. J. Med., 263:10:471
- 20 D Arch. Surg., 81:3:504

December Issue

Q A Source

- I C JAMA, 174:7:842
- 2 C Arch. Surg., 81:4:660
- 3 B Arch. Int. Med., 106:4:483
- 4 A Arch. Psychiat., 3:4:121/429
- 5 E Arch. Derm., 82:4:501
- 6 B New Eng. J. Med., 263:15:728
- 7 E Brit. Med. J., 5204:1005
- 8 A J. Clin. Invest., 39:10:1546
- 9 D J. Chron. Dis., 12:4:428,440
- 10 A J. Urol., 84:4:539
- 11 B Surgery, 48:4:658
- 12 C Arch. Neurology, 3:3:59/267
- 13 * Am. J. Ophth., 50:3:414
- 14 B Am. J. Surg., 100:4:561
- 15 C Anesthesiology, 31:5:477
- 16 A New Eng. J. Med., 263:14:699
- 17 D Lancet, 7152:690
- 18 C Circulation, XII:4:503
- 19 B Cancer, 13:5:921
- 20 E Armed Forces Med. J., 11:10

Supplementary

Q A Source

- 1 C Surgery, 48:5:864
- 2 A Surgery, 48:5:979
- 3 E Proc. Mayo Clinic, 35:22:635
- 4 B Am. J. Roentgen. Nucl. Med., 84:5:945

in led

the d

First t

light g first si tional (maxis

Dosag second 2 per a

^{*} Full credit was given all contestants, regardless of answer checked, due to a defect in the question.



in leading headache clinics. the drug of choice for migraine is

$CAFERGOT^*$

First thought in migraine:

:483 /429

46 3,440

/267

ian

CAFERGOT TABLETS: ergotamine tartrate 1 mg., caffeine 100 mg. (Color: light grav, sugar-coated.) Dosage: 2 at first sign of attack; if needed 1 additional tablet every 1/2 hour until relieved (maximum 6 per attack).

CAFERGOT SUPPOSITORIES: ergotamine tartrate 2 mg., caffeine 100 mg. Dosage: 1 as early as possible in attack; second in 1 hour, if needed (maximum 2 per attack).

When the headache is associated with nervous tension and G. I. disturbance:

CAFERGOT P-B TABLETS: ergotamine tartrate 1 mg., caffeine 100 mg., Bellafoline 0.125 mg., pentobarbital sodium 30 mg. Warning: May be habit forming. (Color: bright green, sugar-coated.) Dosage: same as Cafergot Tablets.

CAFERGOT P-B SUPPOSITORIES: ergotamine tartrate 2 mg., caffeine 100 mg., Bellafoline 0.25 mg., pentobarbital sodium 60 mg. Warning: May be habit forming. Dosage: same as Cafergot Suppositories.



- 5 D Am. J. Roentgen. Nucl. Med., 84:5:958
- 6 A Lancet, 7158:1018
- 7 C Lancet, 7158:1036
- 8 E J. Urol., 84:5:649
- 9 D Arch. Otolaryn., 71:6.64/938
- 10 C Arch. Path., 70:2:261
- 11 A Arch. Ophth., 64:1:111/81
- 12 E Acta Med. Scand., 167:4:253
- 13 D Am. J. Clin. Nutrition, 8:2:147
- 14 D Am. J. Clin. Nutrition, 8:3:369
- 15 B Am. J. Dig. Dis., 5:5:437
- 16 A Am. J. Dig. Dis., 5:6:499
- 17 D Am. J. Gastroent., 34:3:223
- 18 C Am. J. Obs. Gyn., 80:1:104
- 19 A Am. J. Physiology, 198:6:1217
- 20 C Am. J. Cardiology, 6:1:30
- 21 B Am. J. Clin. Path., 34:2:179
- 22 C Am. J. Ophth., 50:2:
- 23 D Am. J. Physiology, 199:1:77
- 24 B Am. J. Path., 36:6:
- 25 E Am. J. Pub. Health, 50:4:998
- 26 B Am. J. Roentgen. Nucl. Med., 84:4:715
- 27 E Am. J. Pub. Health, 50:8:1097
- 28 A Am. J. Physiology, 198:6:1187

- 29 C Gastroenterology, 39:2:178
- 30 D Proc. Soc. Exp. Bio. Med., 104:2:173
- 31 A Am. J. Surg., 100:1:64
- 32 C Proc. Soc. Exp. Bio. Med., 105:1:55
- 33 E J. Canad. Med. Soc., 83:20:1040
- 34 B Proc. Soc. Exp. Bio. Med., 104:2:309
- 35 C Am. J. Med. Sc., 239:6:123/745
- 36 B Proc. Soc. Exp. Bio. Med., 104:4:584
- 37 D J. Clin. Invest., 39:11:1607
- 38 A Arch. Otolaryn., 3:5:34/500
- 39 A Physiol. Rev., 40:2:116
- 40 E Arch. Derm., 82:5:93/701
- 41 C Physiol. Rev., 40:3:580
- 42 C J. Clin. Invest., 39:6:809
- 43 B Physiol. Rev., 40:4:789
- 44 A Lancet, 7142:138
- 45 B Proc. Soc. Exp. Bio. Med., 104:3:432
- 46 B Lancet, 7148:479
- 47 D J. Clin. Endocrin. Metab., 20:6:881
- 48 A Proc. Soc. Exp. Bio. Med., 104:2:209
- 49 C Lancet, 7140:21
- 50 E Proc. Soc. Exp. Bio. Med., 105:1

Y

In

An ed that the of the restrialcoh

faste "goo some duce

worl choo prac

mai mig pha

rın



178 ed.,

ed.,

ed..

i.,

/500 '01

d.,

d.,

cian

The basic question is whether we are to discard the system that has brought us to our present level of health care, and promises much higher levels for the future, in favor of a regulatory strait jacket that stifles initiative, bureaucratizes research, and promises nothing for the future,

You can't go places in a strait jacket...!

An editorial writer recently made the interesting suggestion that the pharmaceutical industry might have avoided much of the current public interest in its affairs if they had simply restricted themselves to making aspirin tablets and rubbing alcohol, competing only by debating which aspirin dissolves faster. • No one has seriously suggested a return to the "good old days" in therapeutics, but there are apparently some who would like to destroy the system that has produced for us the finest medical care in the history of the world. Whether they attack the freedom of the patient to choose his physician, the freedom of the physician in the practice of his profession, or the freedom of the pharmaceutical industry is immaterial. • If the desideratum is simply maintenance of the status quo in health care, medicine might well have rested on its 19th century laurels and the pharmaceutical industry on aspi-

This message is brought to you on behalf of the producers of prescription drugs as a service to the medical profession. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D. C.

rin tablets and rubbing alcohol.

QUIET, PLEASE!

YOUR WIFE'S TALKING



Too Much Hogwash?

Mona M. Steinberg

Having read your article, entitled "Your Wife's Talking," in the September 1960 issue of RESIDENT PHYSICIAN, I felt compelled to write you immediately, and "discuss" some of the ideas stated therein.

Unlike the author of the above-mentioned article, I am not a nurse, and am perhaps not as well-acquainted with the doctor-hospital routines as she is. However, I am a resident's wife, and have been for several years. I feel that I am familiar with the needs and difficulties of being a doctor's wife, and at least as well-acquainted with the needs of marriage as most average wives.

It seems obvious to me that if any marriage (to a man of the medical or any other occupation) were run or based on the ideas that the above author writes about, it would either shortly break up, or send the wife, husband, or children (or all together) into quite serious emotional difficulty.

It is true that we are doctor's wives, but what is more important is that we are also human beings. If we force ourselves to ignore this fact, we are likely to run into some serious troubles, with ourselves as well as with our families

My physici pital. your mailed

Natu ested i about

amaze
that i
these
We ar
our re
follow
or les
of the
ters p
what
hear:
more
wife'

cake
ing"
issue
ten
vou

it fo

My husband is a resident physician in a New York hospital. I have read many of your magazines that are mailed to him.

Naturally, I am most interested in articles written by or about residents' wives.

I have been continually amazed at the "hogwash" that is written by some of these wives for publication. We are continually told that our role in life is to adjust, follow the pattern, and more or less squeeze ourselves out of the picture. Are these letters published because "that's what young doctors want to hear?" Would you publish a more human picture of the wife's situation?

The article that took the cake was "Your Wife's Talking" in the September 1960 issue, page 146. I have written an "answer." — Would you be so kind as to consider it for publication?

MONA M. STEINBERG

and the world. The above author's article seems to me to be completely unrealistic. Perhaps her nurse's training has made her think that marriage should be run like a doctor's office—smoothly, efficiently, and in a very impersonal manner. I doubt that she believes all this herself, or she might not find it necessary to participate in "professionally guided group therapy sessions."

Companionship

She seems to feel that our husbands should be given primarily "the kind of care and support which enables them to function at their best in their work." She tells us to "give him a kiss and leave him alone-if that's the way he wants it," or to "be a good listener." But, if we should want to talk to our husbands, to seek companionship, or to let him know how we think or feel, this is verboten. It seems to be expected of us that we make our own personalities nonexistent. We might talk instead to therapists, but should certainly "never, never start pouring out the annovances of the day," or call hubby at the hospital if one of the children has become quite ill. Ignore the fact that a child's sudden illness might be normally terrifying to any mother, and that



she might just need her husband's comfort or advice as to how to handle this frightening situation.

The above-mentioned author writes that "we wives must be self-sufficient . . ." We wives, or any other wives can never be completely self-sufficient. neither can our husbands-or we would never have needed to get married in the first place. I don't mean that we should be completely dependent, infantile women, but that marriage is largely based on interrelationships and interdependencies. There is no exception in the lives of doctors or their wives. The fact that they carry the "M.D." title does not make them inhuman, or "above it all" in life, or highly superior to the needs of ordinary mortals (an attitude which seems to be prevalent in so many "biggerthan-thou" physicians, and so much medical literature that I have read).

It is not our main job to give our husbands the kind of support which will help them in their work. Marriage is not a job, or we should want to know what we get out of it other than Social Security.

Understanding

Marriage is a life together. It is an adjustment, and a getting relocated, in order to obtain more happiness with ourselves, with each other, and with our environment. The more interdependence, understanding, interrelationship, and, above all, mutual love there exists in a marriage, the more successful will all involved be, and the more contented also will the doctor-husband (or any other husband) be in his work, and on his entire outlook on life.

It is often said that the doctor's main interest should be the care of his patients. How absurd! A doctor's interests are primarily his own, as any human being's are. Any physician who will not admit this, is either fooling himself, or being a malfunctioning individual. When his own personal interests and needs are fully

realize succes with wife, spect, to be and a

and s bands such favor ican them realized, only then will he be successful in his practice and with his patients. His life, his wife, his home, and his self-respect, are part of what he needs to be a successful human being, and also a successful physician.

Let's come off our high horse, and stop trying to give our husbands little professional niceties such as a kiss and a wedge of his favorite cake (the typical American movie ending). Let's give them what we want to give—our-

or or

t we

ocial

tting nore with ronnce, ship, here sucand the hus-

the ard! arily ng's not aim-

ully

cian

selves, our love, and the opportunity to have each other to be strongly dependent on. Let's take the same in return. We didn't marry these men to build up their office practices. We married them in order to secure greater happiness for ourselves. If each of us ignores this and ignores ourself, it's bound to come up in other and more dangerous shapes and forms, and to land one or both of us in a mental institution in a matter of years or even months.



"Miss Wilson, how would you like never having to worry about . . er . . ah . . doctor bills for the rest of your life?"

May 1961, Vol. 7, No. 5

What's Doctor's Name?

His career as researcher, teacher, editor, author and bibliophile is one of the most remarkable of our time. When he died, on May 29, 1960, medicine lost a truly great figure.

He was born in St. Paul, Minnesota, on November 1, 1899.

He was a Rhodes Scholar in Oxford from 1921 to 1923 and received his M.D. from Harvard in 1927. He taught at Oxford and earned three advanced degrees and two honorary degrees there. He was Sterling Professor of Physiology at the Yale Medical School from 1930 to 1951 and Sterling Professor of the History of Medicine from 1951 until 1960.

He served on the National Research Council and was a trustee of the Institute for Advanced Study. He was holder of the Gold Medal of the University of Liege, Order of the British Empire.

Here are three good reasons why you should write "Raudixin" in the treatment of high blood pressure:



1. The whole root, including all its active fractions, is used for maximal antihypertensive activity with minimal sedation.



2. Radioisotope dilution assay (important, but rarely done elsewhere) determines potency.



3. Every Raudixin tablet to reach your patient meets the high Squibb standards for effectiveness, potency and uniformity.

Squibb Standardized Whole Root Rauwolfia Serpentina

SQUIBB Squibb Quality - the Priceless Ingredient

Supply: 50 and 100 mg. tablets.

'Raudixin'® is a Squibb trademark.

Frenc Order past 1 for 1 Ment twice.

He gover in W by th build Army log o lists 1

Hi Harv ogy (







May

French Legion of Honor and Order of Leopold II. He was a past president of the Association for Research in Nervous and Mental Disease, having served twice, in 1939 and 1947.

X-

e-

in

nd

es

e.

of

al

nd

ry

0.

e-

ee

ed

e,

e,

ab-

bb veni-

an

He did much research for the government on aviation medicine in World War II and was cited by the government for his aid in building the collection of the Army Medical Library. The catalog of the Yale Medical Library lists hundreds of his writings.

His best known books are Harvey Cushing (1946), Physiology of the Nervous System (3rd ed., 1949), The Great Medical Bibliographers (1951) and *Text-book of Physiology* (17th ed., 1955).

He was editor of the Journal of the History of Medicine and chiefly instrumental in building up the modern holdings in medical history of the Yale Medical Library. In 1956 a special issue of the Yale Journal of Biology and Medicine was devoted to him, and in 1959 he received the George Sarton Medal of the History of Science Society. Can you identify this doctor?

Answer on page 181.

SOME THINGS CAN'T WAIT! Your family, your future . . . they deserve insurance. Lack of money now need not be a deterring factor. Through a unique financing plan, you can have the Life Insurance and Disability Income Protection you need NOW . . . and pay for it when you're financially able.

Copeland

PLANNED FUTURES, INC.

300 Park Ave. Suite 1616, One La Salle St. Bldg. 2601 Wilshire Blvd. New York 22, N. Y. • Chicago 2, Ill. • Los Angeles 57, Cal.

Ple		d in an insured future. ther information without obligation ance and non-cancellable Disability	RP-5
	NAME	AGE	
	ADDRESS		
	STATE	CITY	
	HOSPITAL		



Mediquiz

These questions were prepared especially for RESIDENT PHYSICIAN by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 185.

1. Polyostotic fibrous dysplasia may best be differentiated from hyperparathyroidism by:

 A) Serum calcium and phosphorus determinations.

B) Tests of intelligence and behavior pattern.

C) The x-ray appearance of the long bones.

 D) The x-ray appearance of the bones of the axial skeleton.

 E) Examination of bone marrow aspirate.

2. Adrenergic nerve impulses cause:

- A) Miosis.
- B) Bronchocontraction.
- C) Increased intestinal motility.
- D) Urinary detrusor contraction.
 - E) Tachycardia.

3. Which one of the following statements concerning adrenal cortical hormones is *incorrect?*

A) The absence of pigmentation in most cases of secondary adrenal insufficiency indicates that an intact anterior pituitary is necessary for typical Addisonian pigmentation.

B) Although doc (desoxycorticosterone) and aldosterone have the same quantitative sodiumretaining activity, doc has a greater influence on carbohydrate metabolism.

C) The normal growth of axillary hair in the male and female, and pubic hair in the female, is dependent on the presence of adrenal cortex.

D) It is generally accepted that the 11.17 oxygenated corti-

Your p ceptive use, de choice

vaginal

'The spe which r Too many, too soon...

...does she know you can help her?

Many patients are unaware that their physician is the best source of contraceptive advice. Your prescription for Delfen or Preceptin assures them the simplest yet most effective contraceptive protection available. Accurate tests* for spermicidal potency, as well as years of clinical use, demonstrate that ORTHO contraceptive products are instantaneously spermicidal. The choice between Delfen and Preceptin is one of individual esthetic preference.

ng nal

tary tes is an

or-

ve m-

ate

of

fehe es-

ed

tiian Delfen Preceptin

The spermicidal potency of all ORTHO products is controlled by the Titration Test and the Sander-Cramer Test, which more closely duplicate vaginal conditions during coitus than other tests.



coids antagonize the physiological effects of the posterior pituitary antidiuretic hormone.

E) Cortisone and hydrocortisone increase secretion of gastric HC1 and pepsin, and of pancreatic enzymes.

4. The serum vitamin B₁₂ level is raised in:

- A) Psoriasis.
- B) Pulmonary emphysema.
- C) Chronic myelogenous leukemia.
 - D) Gastric carcinoma.
 - E) Osteoporosis.
 - 5. Death in subjects with idio-

pathic pericarditis is usually due to:

7. 7

nostic

tion of

A)

B)

C)

D) succes

E)

cemia

is infl

ing fa

tents.

A)

B)

C) D) E)

atresi nares

> A) B) C)

D)

E)

10 of I fema A

> B C

May

ment

water

- A) Cardiac tamponade.
- B) Congestive heart failure.
- C) Uremia.
- D) Coexistent valvular disease.
- E) Cardiac arrhythmia.

6. Which one of the following conditions is least likely to be responsible for hypocalcemic tetany?

- A) Sprue.
- B) Avitaminosis D.
- C) Glomerular insufficiency.
- D) Renal tubular acidosis.
- E) Severe diarrhea.

DERMATOLOGIC

Ointment 3% Ointment 3% with Hydrocortisone 2% (each with methylparaben 2.4% and propylparaben 0.6% in a wool fat-petrolatum base)



ACHROMYC

a standard in topical antibiotic therapy

LEBERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.



Resident Physician

- 7. The most definitive diagnostic procedure for demonstration of Addison's disease is:
 - A) Cutler-Power-Wilder test.
- B) Robinson-Kepler-Power water test.
 - C) 4-hour ACTH test.

due

e.

ease.

wing

be

emic

cy.

cian

- D) 8-hour ACTH test on two successive days.
- E) 24-hour fast for hypoglycemia.
- 8. The absorption of calcium is influenced by all of the following factors except the:
 - A) Intake of Vitamin D.
- B) pH of the intestinal contents.
 - C) Integrity of the ileum.
 - D) Amount of fat in the diet.
 - E) Intake of phosphorus.
- **9.** The most common cause of atresia of the anterior or posterior nares is:
 - A) Tuberculosis.
 - B) Trauma.
 - C) Syphilis.
- D) Defective prenatal development.
 - E) Moniliasis.
- 10. The most common cause of precocious puberty in the female is:
 - A) Granulosa cell tumor.
 - B) A neurological defect.
 - C) A constitutional defect.

- D) Adrenal tumor.
- E) Theca cell tumor.
- 11. Which of the following statements concerning carcinoma of the cervix is *not* correct?
- A) Carcinoma of the cervix is rare in Jewish women and Catholic nuns.
- B) Carcinoma of the cervix is rarely associated with complete prolapse of the uterus.
- C) The most malignant uterine cancer is adenocarcinoma of the cervix.
- D) Women who have borne children are far more susceptible to carcinoma of the cervix than women who have not.
- E) Of the two main types of carcinoma of the cervix, adenocarcinoma is about 15 times as frequent as squamous cell carcinoma.
- 12. In occiput posterior positions rotation occurs through:
 - A) 45 degrees.
 - B) 90 degrees.
 - C) 120 degrees.
 - D) 135 degrees.
 - E) 180 degrees.
- 13. Abdominal enlargement is more pronounced in multigravidas than in primigravidas because in the former the:
- A) Fetus develops more rapidly.

- B) Uterus is larger.
- C) Uterus enlarges more rapidly.
- D) Hormonal changes occur more rapidly.
- E) Abdominal wall has lost some of its tone.
- 14. An 11-year-old boy is found to have von Reckling-hausen's neurofibromatosis. The child complains of failing vision. This is most probably due to:
 - A) A pinealoma.
- B) An astrocytoma of the occipital lobes.
 - C) Bilateral cataracts.
- D) A glioma of the optic chiasm.
- E) A neurofibroma of an optic nerve.

- 15. Which of the following conditions is the most common cause of hearing disability in children?
 - A) Varicella.
 - B) Variola.
 - C) Ornithosis.
 - D) Rubella.
 - E) Pertussis.
- 16. Barbiturate toxicity is most accurately diagnosed by determining the:

I(A) Do

2(E)

3(B)

4(C)

5(A)

6(D)

7(D)

8(C)

9(D)

10(C)

H(E)

12(D)

13(E)

14(D)

15(D)

16(E)

May 19

G

tie

B

- A) Hemoglobin saturation.
- B) Urinary Na and Cl.
- C) Blood pH.
- D) Versene (EDTA) binding.
- E) Blood concentration.

For answers and references, please turn to page 185.

Third Mediquiz® Booklet Ready

A third volume of 150 Mediquiz® questions, answers and references, compiled by the Professional Examination Service, Division of the American Public Health Association, is now available in booklet form for \$1 per copy. The supply of booklets is limited. To be certain you get your copy, send your dollar now to:

Professional Examination Service
Department 40-C
American Public Health Association
1790 Broadway, New York City 19, New York.

Please specify "Volume 3." (Copies of Volumes I and 2 are available at \$I each for those who missed out on these valuable study aids.)



on in

DV

Ig.

an

- I(A) Duncan, Diseases of Metabolism, 3rd ed., 261.
- 2(E) Goodman and Gilman, The Pharmacological Basis of Therapeutics, 1955, 395.
- 3(B) Cecil and Loeb, Textbook of Medicine, 9th ed., 769-70.
- 4(C) Halsted, J. A., et al. "Serum and Tissue Concentration of Vitamin B₁₂ in Certain Pathologic States," N. Engl. J. Med., 260:12, 3/19/ 59, 579.
- 5(A) Reid, E. A. S., et al., "Idiopathic Pericarditis," Ann. Int. Med., 45:99, 1956.
- 6(D) Cecil and Loeb, Textbook of Medicine, 9th ed., 792.
- 7(D) Cecil and Loeb, Textbook of Medicine, 9th ed., 774.
- 8(C) Nelson, W. E., Textbook of Pediatrics, 6th ed., 85.
- 9(D) Davis, Christopher's Textbook of Surgery, 6th ed., 1956, 251.
- 10(C) Novak and Novak, Textbook of Gynecology, 1956, 680.
- II(E) Novak and Novak, Textbook of Gynecology, 1956, 239.
- 12(D) Eastman, Williams Obstetrics, 11th ed., 1956, 405.
- 11th ed., 1956, 405, 13(E) Eastman, Williams Obstetrics,
- 11th ed., 1956, 262. 14(D) Nelson, W. E., Textbook of Pediatrics, 6th ed., 1182.
- IS(D) Slobody, Survey of Clinical Pediatrics, 1955, 62.
- Ib(E) Parker, B., "Emergency Treatment of Patients in Coma Due to Drug Intoxication," Med. Clin. No. Am., 5/1957, 833.

FULLY APPROVED THREE-YEAR Psychiatric Residency: Deans' Committee supervised didactic-clinical program on 95-bed Psychiatric Service in 500-bed general hospital in famed Chicago Medical Center; affiliated with University of Illinois, Chicago Medical School, Loyola University, Institute for Juvenile Research, Chicago State Hospital; very large active outpatient clinic and day center; program is characterized by orientation to the individual resident and high competency of teaching staff. Write: Louis Halperin, MD., Veterans Administration West Side Hospital, 820 South Damen Avenue, Chicago 12, Illinois.

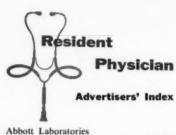
RESIDENTS IN PATHOLOGY needed for July I or earlier. 920-bed general hospital, Three Board certified staff pathologists. Three-year approval. Affiliated training at Children's Medical Center and Free Hospital for Women, Will adjust appointment dates to suit your schedule. Salary \$3495 to \$4475. U.S. or Canadian citizenship essential. Veterans Administration Hospital, 150 South Huntington Avenue, Boston 30 Massachusetts; John D. Houghton, M.D., Pathologist.

FOR SALE OR RENT

- OFFICE SPACE AVAILABLE for Pediatrician, Orthopedist or E.N.T. in new air-conditioned medical building, Maryland suburb of Washington, D. C. Within 10 minutes of five hospitals, Other offices in building now occupied by Internist, Ob-Gya, Dentist and Podiatrist, Rental 10% of gross receipts or flat rate. Write: S.J.N. Suger, M.D., 4637 Eastern Avenue, Washington 18, D. C.
- FOR SALE: Home-office-attached-750 square foot office; modern, air-conditioned, corner; 5 minutes from hospital, schools and churches; Rochester, New York, Grossing \$35,000 yearly; suitable for General Practice or Internal Medicine, Write: Box 6105, Resident Physician, 1447 Northern Boulevard, Manhasset, New York.
- MEDICAL OFFICES—New York City—300 to 600 square feet or larger; will partition; air-conditioned; new apartment house; Greenwich Village; occupancy May 1st, 1961. Call Hanfield, Hillyer and Bell, Inc., Oregon 4-9100.

PRACTICE FOR SALE

COLORADO—WESTERN; Unopposed general practice; small fown with a supported hospital; 1959 gross \$30,000; well equipped office with no down payment; good records; 94 percent collections, Write: Woodrow Gledhill, Hayden Colorado.



(Venopak, Secondary)	24, 25
American Sterilizer Co.	
American Sterilizer Co. (Amsco Dynapoise)	12, 33
Ames Co., Inc.	
(Combistix)	ver 3
Ayerst Laboratories	
(Murel-S.A.)	
(Premarin Intravenous)	4
baker Laboratories, Inc., The	
(Modified Milk)	113
Birtcher Corp., The	
(Ultrasonics)	3
(Ultrasonics) Burroughs Wellcome & Co., Inc.	
(Student Anthology)	46
Colwell Co., The	
(Daily Log)	38
(Daily Log) Copeland Planned Futures, Inc.	
(Insurance & Disability	
Income Protection)	167
Eaton Laboratories	
(Furacin Vaginal Suppositories)	101
(Furoxone)	23
Endo Laboratories	
(Coumadin) (Percodan) Fleet Co., Inc., C. B.	141
(Percodan)	12
Fleet Co., Inc., C. B.	
(Fleet Enema) Holland-Rantos Co., Inc.	121
Holland-Rantos Co., Inc.	
(Koro-Flex)	39
(Koro-Flex) Knoll Pharmaceutical Co.	
(Dilaudid)	107
(Dilaudid) Lederle Laboratories, Division of	
American Cyanamid Co.	
(Achromycin Dermatologic)	170
(Achromycin IM, IV)	34
(Aristocort) Opposite page 1	9: 19
(Stresscaps)	155
McNeil Laboratories, Inc.	
(Butiserpine)	117
(Nactisol)	
(Twiston)	47
Mead Johnson Laboratories	
(Enfamil)	53
(Sustagen) Co	ver 4
(Enfamil) (Sustagen)	
of Merck & Co., Inc.	
(Albumisol)	127
(Decadron)Co	ver 2
(Decadron Phosphate Injection)	52

(Hydrocortone Phosphate Injection) 1: (Urecholine) 48, 48 Minnesota Mining and Manufacturing Co. (Scotch Brand Surgical Tape) 105 Organon, Inc. (Durabolin) 111 Ortho Pharmaceutical Corp. (Delfen, Preceptin) 160 (Sporostacin Cream) 26 Parke, Davis & Co. (Midicel) 30 Pharmaceutical Manufacturers Association (Institutional) 161 Physicians Casualty & Health Associations (Accident & Hospital Insurance) 179 Professional Printing Co., Inc. (Histacount) 178 Resident Physician 36 Robins Co., Inc., A. II. (Adabee) 31 Robins Co., Inc., A. II. (Adabee) 19 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 55 (Librium) 94, 92 Randoz Pharmaceuticals (Cafergot) 159 (Mellaril) 16, 17 Schering Corp. (Metreton) 55 Rearle & Co., G. D. (Nilevar) 100 Robins & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 17 Sampax Inc. (Tampax) 33 LS. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 17 Jampax Inc. (Tampax) 41 through 17 Jampax Inc. (Tampax) 41 through 17 Jampax Inc. (Tampax) 122 (Orinase) 123 (Orinase) 125 (Varier-Chilcott Laboratories (Anusol, Anusol-HC) 125 (Pyridium) 125		
Injection) (Urecholine) Minnesota Mining and Manufacturing Co. (Scotch Brand Surgical Tape) Organon, Inc. (Durabolin) Ortho Pharmaceutical Corp. (Delfen, Preceptin) (Sporostacin Cream) Orbarke, Davis & Co. (Midicel) Orbarmaceutical Manufacturers Association (Institutional) Orbarmaceutical Manufacturers Association (Institutional) Orbarmaceutical Manufacturers Association (Institutional) Orbarmaceutical Manufacturers Association (Institutional) Orbarmaceutical Manufacturers Association (Accident & Hospital Insurance) Orbarma-Moore Co. (Neo-Polycin Ointment) Orbaroresional Printing Co., Inc. (Histacount) Orbaroresional Printing Co., Inc. (Hoffmann-LaRoche Inc. (Gantrisin) Orbaroresional Printing Co., Inc. (Hoffmann-LaRoche Inc. (Gantrisin) Orbaroresional Printing Co., Inc. (Hoffmann-LaRoche Inc. (Gantrisin) Orbaroresional Printing Co., Inc. (Horbaroresional Printing Co., Inc. (Inc., A. II. (Adabee) Orbaroresional Printing Co., Inc. (Inc., A. II.	(Diuril)	135
(Urecholine) 48, 49 Minnesota Mining and Manufacturing Co. (Scotch Brand Surgical Tape) 105 Prganon, Inc. (Durabolin) 111 Profto Pharmaceutical Corp. (Delfen, Preceptin) 169 (Sporostacin Cream) 26 Parke, Davis & Co. (Midicel) 30 Pharmaceutical Manufacturers Association (Institutional) 161 Physicians Casualty & Health Associations (Accident & Hospital Insurance) 179 Professional Printing Co., Inc. (Histacount) 20 Professional Printing Co., Inc. (Histacount) 36 Robins Co., Inc., A. II. (Adabee) 36 Robins Co., Inc., A. II. (Adabee) 37 Robins Co., Inc., A. II. (Adabee) 38 Robins Co., Inc., A. II. (Adabee) 39 Robins Co., Inc., A. II. (Adabee) 30 Robins Co., Inc., A. II. (Adabee) 31 Robins Co., Inc., A. II. (Ad	(Hydrocortone Phosphate	
Minnesota Mining and Manufacturing Co. (Scotch Brand Surgical Tape) 105 Praganon, Inc. (Durabolin) 111 Ortho Pharmaceutical Corp. (Delfen, Preceptin) 26 Parke, Davis & Co. (Midicel) 36 Pharmaceutical Manufacturers Association (Institutional) 161 Physicians Casualty & Health Associations (Accident & Hospital Insurance) 179 Pitman-Moore Co. (Neo-Polycin Ointment) 20 Professional Printing Co., Inc. (Histacount) 178 Resident Physician 36 Robins Co., Inc., A. II. (Adabee) 139 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 57 Resident Physician 58 Roche Laboratories Division of Hoffmann-LaRoche Inc. (Gantrisin) 57 Resident Physician 58 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 57 Resident Physician 58 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 58 Roche Laboratories, Division of Clibrium) 54 Resident Physician 59 Roche Laboratories (Cafergot) 159 Roche Laboratories (Cafergot) 159 Roche Laboratories (Cafergot) 159 Roche Laboratories (Cafergot) 159 Roche Laboratories (Compazine, Stelazine, Thorazine) 159 Roche Co. D. (Milevar) 103 Roche Resident Physician 61 Roche Resident Physician 62 Roche Laboratories (Compazine, Stelazine, Thorazine) 103 Roche Resident Physician 64 Roche Resident Physician 65 Roche Laboratories (Campax) 166 Roche Resident Physician 65 Roche Laboratories 122 Roche Laboratories 123 Roche Laboratories 124 Roche Resident Physician 133 Roche Resident Physician 134 Roche Resident Physician 135 Roche Resident Physician 136 Roche Resident Physician 137 Roche Resident Physician 137 Roche Resident Physician 138 Roche Resident Physician 139 Roche Laboratories 108 Roche Laboratories 10		49
(Durabolin) (Durabolin) (Delfen, Preceptin) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Ask Davis & Co. (Midicel) (Institutional) (Institutional) (Institutional) (Institutional) (Institutional) (Institutional) (Institutional) (Accident & Hospital Insurance) (Accident & Hospital Insurance) (Neo-Polycin Ointment) (Oince, Polycin Ointment) (Neo-Polycin Ointment) (Neo-Polycin Ointment) (Neo-Polycin Ointment) (Neo-Polycin Ointment) (Histacount) (Essident Physician (Adabee) (Adabee) (Contrain) (Calerian) (Mellaril) (Mell	Minnesota Mining and	
(Durabolin) (Durabolin) (Delfen, Preceptin) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Ask Davis & Co. (Midicel) (Institutional) (Institutional) (Institutional) (Institutional) (Institutional) (Institutional) (Institutional) (Accident & Hospital Insurance) (Accident & Hospital Insurance) (Neo-Polycin Ointment) (Oince, Polycin Ointment) (Neo-Polycin Ointment) (Neo-Polycin Ointment) (Neo-Polycin Ointment) (Neo-Polycin Ointment) (Histacount) (Essident Physician (Adabee) (Adabee) (Contrain) (Calerian) (Mellaril) (Mell	Manufacturing Co.	
(Durabolin) (Durabolin) (Delfen, Preceptin) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Sporostacin Cream) (Ask Davis & Co. (Midicel) (Institutional) (Institutional) (Institutional) (Institutional) (Institutional) (Institutional) (Institutional) (Accident & Hospital Insurance) (Accident & Hospital Insurance) (Neo-Polycin Ointment) (Oince, Polycin Ointment) (Neo-Polycin Ointment) (Neo-Polycin Ointment) (Neo-Polycin Ointment) (Neo-Polycin Ointment) (Histacount) (Essident Physician (Adabee) (Adabee) (Contrain) (Calerian) (Mellaril) (Mell	(Scotch Brand Surgical Tape).	103
(Delfen, Preceptin) 169 (Sporostacin Cream) 26 Parke, Davis & Co. (Midicel) 30 Pharmaceutical Manufacturers Association (Institutional) 161 Physicians Casualty & Health Associations (Accident & Hospital Insurance) 179 Professional Printing Co., Inc. (Histacount) 20 Professional Printing Co., Inc. (Histacount) 179 Pessident Physician 36 Robins Co., Inc., A. II. (Adabee) 139 Robins Co., Inc., A. II. (Adabee) 139 Robins Co., Inc., A. II. (Adabee) 139 Robins Co., Inc., A. II. (Adabee) 150 Robins Co., Inc., A. II. (Adabee) 15	(Durabolin)	111
(Sporostacin Cream) 26 Parke, Davis & Co. (Midicel) 30 Pharmaceutical Manufacturers Association (Institutional) 16 Physicians Casualty & Health Associations (Accident & Hospital Insurance) 179 Professional Printing Co., Inc. (Histacount) 20 Professional Printing Co., Inc. (Histacount) 36 Resident Physician 36 Robins Co., Inc., A. II. (Adabee) 31 Robins Co., Inc., A. II. (Adabee) 40 Robins Co., Inc., A. II. (Adabee) 51 Robins Co., Inc., A. II. (Adabee) 61 Robins Co., Inc., A. II. (Adabee) 75 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 94, 95 Roche Laboratories, Division of (Librium) 94, 95 Roche Laboratories, Division of (Mellaril) 16, 17 Robert Cafergot) 159 Robins	Ortho Pharmaceutical Corp.	
Parke, Davis & Co. (Midicel) 30 Pharmaceutical Manufacturers Association (Institutional) 161 Physicians Casualty & Health Associations (Accident & Hospital Insurance) 179 Pitman-Moore Co. (Neo-Polycin Ointment) 20 Professional Printing Co., Inc. (Histacount) 178 Resident Physician 36 Robins Co., Inc., A. II. (Adabee) 139 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 57 Resident Physician 36 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 57 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 58 Roche Laboratories 01 Roche Laboratories 02 Roche Laboratories 05 Roche Laboratories 06 Roche Laboratories 07 Roche Laboratories 0	(Sporostacin Cream)	
(Midicel) Pharmaceutical Manufacturers Association (Institutional) Physicians Casualty & Health Associations (Accident & Hospital Insurance) Pirman-Moore Co. (Neo-Polycin Ointment) Professional Printing Co., Inc. (Histacount) Professional Printing Co., Inc. (Gantrisin) (Librium) 94, 95 Sandoz Pharmaceuticals (Cafergot) (Mellaril) 166, I75 Sandoz Pharmaceutical Corp. (Metreton) Solical Professional Printing Co., Inc. (Compazine, Stelazine, Thorazine) Olin Mathieson Chemical Corp. (Raudixin) 166, 175 Sampax Inc. (Tampax) 159 Ustamin & Pharmaceutical Corp. (Emivan) 159 Vitamin & Pharmaceutical Corp. (Corinase) 121 (Orinase) 122 (Orinase) 133 (Tedral SA) 131 Vitile Laboratories (Incorphyd) 134 (Hevonbed) 135 (Tedral SA) 136 137 138 139 139 130 130 131 131 131 131 131 131 131 131	Parke. Davis & Co.	20
Association (Institutional) 161 Physicians Casualty & Health Associations (Accident & Hospital Insurance) 179 Pitman-Moore Co. (Neo-Polycin Ointment) 20 Professional Printing Co., Inc. (Histacount) 178 Resident Physician 36 Robins Co., Inc., A. II. (Adabee) 139 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 56 (Librium) 94, 91 Sandoz Pharmaceuticals (Cafergot) 159 (Mellaril) 16, 17 Schering Corp. (Metreton) 55 Searle & Co. G. D. (Nilevar) 103 Smith Kline & French Laboratories (Compazine, Stelazine, Thorazine) 51 Squibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 173 Rampax Inc. (Tampax) 33 J.S. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 47 Jepion Co., The (Medrol Medules) 129 (Orinase) 58 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 133 (Tedral SA) 131 Vinter Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 109 Vinthrop Laboratories	(Midicel)	30
Association (Institutional) 161 Physicians Casualty & Health Associations (Accident & Hospital Insurance) 179 Pitman-Moore Co. (Neo-Polycin Ointment) 20 Professional Printing Co., Inc. (Histacount) 178 Resident Physician 36 Robins Co., Inc., A. II. (Adabee) 139 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 56 (Librium) 94, 91 Sandoz Pharmaceuticals (Cafergot) 159 (Mellaril) 16, 17 Schering Corp. (Metreton) 55 Searle & Co. G. D. (Nilevar) 103 Smith Kline & French Laboratories (Compazine, Stelazine, Thorazine) 51 Squibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 173 Rampax Inc. (Tampax) 33 J.S. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 47 Jepion Co., The (Medrol Medules) 129 (Orinase) 58 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 133 (Tedral SA) 131 Vinter Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 109 Vinthrop Laboratories	Pharmaceutical Manufacturers	
Physicians Casualty & Health Associations (Accident & Hospital Insurance) Professional Printing Co., Inc. (Neo-Polycin Ointment) Professional Printing Co., Inc. (Histacount) tesident Physician Robins Co., Inc., A. II. (Adabee) Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) (Librium) 94, 99 Randoz Pharmaceuticals (Cafergot) (Mellarii) Inchering Corp. (Metreton) Searle & Co, G. D. (Nilevar) Mith Kline & French Laboratories (Compazine, Stelazine, Thorazine) Squibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) Randixin) Randixin Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) Randixin) Randixin Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) Randixin) Randixin Sons, E. R., Division Randixin) Randixin Sons, E. R., Division Randixin Sons, E. R., Division Randixin) Randixin Sons, E. R., Division Randixin) Randixin) Randixin) Randixin Sons, E. R., Division Randixin) Randixin Sons, E. R., Division Randixin Sons, E. R., Division Randixin) Randixin Sons, E. R., Division Randixin Sons Ran	Association	161
Associations (Accident & Hospital Insurance) Pitman-Moore Co. (Neo-Polycin Ointment) Professional Printing Co., Inc. (Histacount) Resident Physician Robins Co., Inc., A. II. (Adabee) Robins Co., Inc., A. II. (Robins Robins Co., Inc., In	Physicians Casualty & Health	141
All man-Moore Co. (Neo-Polycin Ointment) Professional Printing Co., Inc. (Histacount) Professional Printing Co., Inc. (Adabee) Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) (Librium) 94, 95 Roche Laboratories (Cafergot) (Mellarii) 16, 17 Schering Corp. (Metreton) Siearle & Co, G. D. (Nilevar) Mith Kline & French Laboratories (Compazine, Stelazine, Thorazine) Siguibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 173 Rampax Inc. (Tampax) J.S. Vitamin & Pharmaceutical Corp. (Emivan) Pjohn Co., The (Medrol Medules) (Orinase) Varner-Chilcott Laboratories (Anusol, Anusol-HC) (Sinutab) 133 (Tedral SA) 131 Vitile Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) Vinthrop Laboratories (Il evonted)	Associations	
(Neo-Polycin Ointment) 20 Professional Printing Co., Inc. (Histacount) 33 Resident Physician 36 Robins Co., Inc., A. II. (Adabee) 31 Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 94, 95 Rodrough Standard Stan	(Accident & Hospital Insurance)	179
(Histacount) (Histacount) (Resident Physician 36 (Robins Co., Inc., A. II. (Adabee) (Adabee) (Adabee) (Oche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 56 (Librium) 94, 95 (Sandoz Pharmaceuticals (Cafergot) 159 (Mellaril) 16, 17 (Cafergot) 55 (Mellaril) 16, 17 (Cafergot) 50 (Mellaril) 16, 17 (Cafergot) 103 (Metreton) 55 (Cafergot) 103 (Milevar) 104 (Milevar) 105 (Milevar) 106 (Milevar) 107 (Milevar) 107 (Milevar) 108 (Compazine, Stelazine, Thorazine) 51 (Guibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 17 (Tampax) 35 (JS. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 45 (Jornase) 122 (Orinase) 123 (Orinase) 124 (Orinase) 125 (Anusol, Anusol-HC) 126 (Pyridium) 133 (Tedral SA) 131 (Vinterp Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 (Ill evorhed) 13	(Neo-Polycin Ointment)	20
(Histacount) (Histacount) (Resident Physician 36 (Robins Co., Inc., A. II. (Adabee) (Adabee) (Adabee) (Oche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) 56 (Librium) 94, 95 (Sandoz Pharmaceuticals (Cafergot) 159 (Mellaril) 16, 17 (Cafergot) 55 (Mellaril) 16, 17 (Cafergot) 50 (Mellaril) 16, 17 (Cafergot) 103 (Metreton) 55 (Cafergot) 103 (Milevar) 104 (Milevar) 105 (Milevar) 106 (Milevar) 107 (Milevar) 107 (Milevar) 108 (Compazine, Stelazine, Thorazine) 51 (Guibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 17 (Tampax) 35 (JS. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 45 (Jornase) 122 (Orinase) 123 (Orinase) 124 (Orinase) 125 (Anusol, Anusol-HC) 126 (Pyridium) 133 (Tedral SA) 131 (Vinterp Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 (Ill evorhed) 13	Professional Printing Co., Inc.	-
(Adabee) (Adabee) (Adabee) (Adabee) (Ache Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) (Librium) (Adaptation) (Adaptatio	(Histacount)	179
(Adabee) (Adabee) (Adabee) (Adabee) (Ache Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin) (Librium) (Adaptation) (Adaptatio	Resident Physician	36
Roche Laboratories, Division of Hoffmann-LaRoche Inc. (Gantrisin)		139
Hoffmann-LaRoche Inc. (Gantrisin) 56 (Librium) 94, 92 Sandoz Pharmaceuticals (Cafergot) 159 (Mellaril) 16, 17 Schering Corp. (Metreton) 55 Searle & Co, G. D. (Nilevar) 103 Smith Kline & French Laboratories (Compazine, Stelazine, Thorazine) 51 Guibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 175 Sampax Inc. (Tampax) 35 J.S. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 45 Jopiohn Co., The (Medrol Medules) 121 (Orinase) 54 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 131 (Tedral SA) 131 Vhite Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 Vinthrop Laboratories	Roche Laboratories, Division of	***
(Catergot) 159 (Mellaril) 16, 17 Ichering Corp. (Mellaril) 16, 17 Ichering Corp. (Milevar) 103 mith Kline & French Laboratories (Compazine, Stelazine, Thorazine) 51 Iquibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 175 Iampax Inc. (Tampax) 33 J.S. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 45 Ipjohn Co., The (Medrol Medules) 122 (Orinase) 54 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 130 (Sinutab) 133 (Tedral SA) 131 Vhite Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 Vinthrop Laboratories (Ilevanhed) 17	Hoffmann-LaRoche Inc.	
(Catergot) 159 (Mellaril) 16, 17 Ichering Corp. (Mellaril) 16, 17 Ichering Corp. (Milevar) 103 mith Kline & French Laboratories (Compazine, Stelazine, Thorazine) 51 Iquibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 175 Iampax Inc. (Tampax) 33 J.S. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 45 Ipjohn Co., The (Medrol Medules) 122 (Orinase) 54 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 130 (Sinutab) 133 (Tedral SA) 131 Vhite Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 Vinthrop Laboratories (Ilevanhed) 17	(Gantrisin)	05
(Catergot) 159 (Mellaril) 16, 17 Ichering Corp. (Mellaril) 16, 17 Ichering Corp. (Milevar) 103 mith Kline & French Laboratories (Compazine, Stelazine, Thorazine) 51 Iquibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 175 Iampax Inc. (Tampax) 33 J.S. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 45 Ipjohn Co., The (Medrol Medules) 122 (Orinase) 54 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 130 (Sinutab) 133 (Tedral SA) 131 Vhite Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 Vinthrop Laboratories (Ilevanhed) 17	Sandoz Pharmaceuticals	, 22
(Mellarii) 16, 17 (Metreton) 55 (Metreton) 55 (exarle & Co, G. D. (Nilevar) 103 (mith Kline & French Laboratories (Compazine, Stelazine, Thorazine) 51 (Guibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 175 (ampax Inc. (Tampax) 33 J.S. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 45 (pjohn Co., The (Medrol Medules) 122 (Orinase) 54 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 133 (Tedral SA) 131 Vhite Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 Vinthrop Laboratories 17 (Hevorhed) 17	(Carergot)	139
(Metreton) 20 searle & Co, G. D. (Nilevar) 103 searle & Co, G. D. (Nilevar) 103 searle & Co, G. D. (Nilevar) 104 searle & Co, G. D. (Nilevar) 105 searle & Compazine, Stelazine, Thorazine) 51 squibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 173 sampax Inc. (Tampax) 33 J.S. Vitamin & Pharmaceutical Corp. (Emivan) 41 through (John Co., The (Medrol Medules) 121 (Orinase) 54 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 130 (Tedral SA) 131 (Vinteral SA) 131 (Vinteral SA) 131 (Mol-Iron Chronosules) 108, 108 (Mol-Iron Chronosules) 108, 108 (Mol-Iron Chronosules) 108, 108 (Mol-Iron Chronosules) 108, 108 (Metrop Laboratories) 108, 108 (Metrop Laboratories) 108 (Metrop Lab	(Mellarii)	, 17
(Nilevar) mith Kline & French Laboratories (Compazine, Stelazine, Thorazine) quibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) Tampax Inc. (Tampax) J.S. Vitamin & Pharmaceutical Corp. (Emivan) Jojohn Co., The (Medrol Medules) (Orinase) Varner-Chilcott Laboratories (Anusol, Anusol-HC) (Sinutab) Jistinutab (Sinutab) Jistinutab (Mol-Iron Chronosules) Jios, 108, 109 Vinthrop Laboratories	(Metreton)	55
(Nilevar) mith Kline & French Laboratories (Compazine, Stelazine, Thorazine) quibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) Tampax Inc. (Tampax) J.S. Vitamin & Pharmaceutical Corp. (Emivan) Jojohn Co., The (Medrol Medules) (Orinase) Varner-Chilcott Laboratories (Anusol, Anusol-HC) (Sinutab) Jistinutab (Sinutab) Jistinutab (Mol-Iron Chronosules) Jios, 108, 109 Vinthrop Laboratories	searle & Co, G. D.	
(Compazine, Stelazine, Thorazine) 5 squibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 173 ampax Inc. (Tampax) 35 J.S. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 45 Jojohn Co., The (Medrol Medules) 59 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 8 (Sinutab) 133 (Tedral SA) 131 Vhite Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 109 Vinthrop Laboratories	(Nilevar)	103
Thorazine) Stapubb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 173 ampax Inc. (Tampax) 33 J.S. Vitamin & Pharmaceutical Corp. (Emivan) 41 through 179 pjohn Co., The (Medrol Medules) 121 (Orinase) 54 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 128 (Sinutab) 133 (Tedral SA) 131 Vhite Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 Vinthrop Laboratories	(Compazine Stelazine	
Squibb & Sons, E. R., Division of Olin Mathieson Chemical Corp. (Raudixin) 166, 173	Thorazine)	51
(Raudixin) 166, 173 ampax Inc. 33 (Tampax) 35 J.S. Vitamin & Pharmaceutical Corp. 41 through 45 (Emivan) 41 through 45 Jpjohn Co., The (Medrol Medules) 122 (Orinase) 54 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 4 (Sinutab) 131 (Tedral SA) 131 Vhite Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 Vinthrop Laboratories 1108, 108 (Il evorphed) 33	squibb & Sons, E. R., Division of	1
Ampax Inc. (Tampax) 35	Olin Mathieson Chemical Corp.	175
(Tampax) 33 25 25 25 25 25 25 25	ampay Inc	1/3
J.S. Vitamin & Pharmaceutical Corp. (Emivan)	(Tampay)	35
(Emivan) 41 through 45 Jpjohn Co., The (Medrol Medules) 121 (Orinase) 54 Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 4 (Sinutab) 133 (Tedral SA) 131 Vhite Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 109 Vinthrop Laboratories 108, 109	J.S. Vitamin & Pharmaceutical	п
John Co., The (Medrol Medules) 121 (Orinase) 54 (Orinase) 54 (Varner-Chilcott Laboratories (Anusol, Anusol-HC) 129 (Pyridium) 8 (Sinutab) 133 (Tedral SA) 131 (Valid Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 (Mol-Iron Chronosules) 108, 108 (Mol-Iron Laboratories (Il evontation) 108, 108 (Il evontation)	(F	- 45
(Orinase) Varner-Chilcott Laboratories (Anusol, Anusol-HC) (Pyridium) (Sinutab) 133 (Tedral SA) Vhite Laboratories, Inc. (Gitaligin) (Gitaligin) 22 (Mol-Iron Chronosules) 108, 109 Vinthrop Laboratories (Levonhed) 23	Jpiohn Co., The	47
(Orinase) Varner-Chilcott Laboratories (Anusol, Anusol-HC) (Pyridium) (Sinutab) 133 (Tedral SA) Vhite Laboratories, Inc. (Gitaligin) (Gitaligin) 22 (Mol-Iron Chronosules) 108, 109 Vinthrop Laboratories (Levonhed) 23	(Medrol Medules)	123
(Anusol, Anusol-HC) 129 (Pyridium) 8 (Sinutab) 133 (Tedral SA) 131 Vhite Laboratories, Inc. (Gitaligin) 22 (Mol-Iron Chronosules) 108, 108 Vinthrop Laboratories 108, 108 (Levorhed) 37	(Orinase)	54
(Pyridium) 8 (Sinutab) 133 (Tedral SA) 133 Vhite Laboratories, Inc. (Gitaligin) (Mol-Iron Chronosules) 108, 109 Vinthrop Laboratories 108, 109	(Apusol Apusol-HC)	129
133 134 135 136 137	(Pyridium)	8
(Mol-Iron Chronosules) 108, 109 Vinthrop Laboratories		133
(Mol-Iron Chronosules) 108, 109 Vinthrop Laboratories	(Tedral SA)	131
(Levophed) 37	(Gitaligin)	22
(Levophed) 37	(Mol-Iron Chronosules) 108,	109
Vyeth Laboratories	vinthrop Laboratories	
(C M A)	(Levopned)	31
(3-M-A)	(S-M-A)	. 29